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ARTICLE IX.

PRACTICAL REMARKS ON BLOOD-LETTING.

By D. B. TRIMBLE, M.D., of Chicago, Ill.

As certain medicines have, at one period, obtained great celebrity in the cure of diseases, and, after a time, have been treated with partial or total neglect, either justly or without cause; so has it been with blood-letting, to a certain, and probably to an unjust, extent. That, in the hands of the profession, a generation or two past, it was used to an injudicious and injurious degree, there can be but little doubt; but the danger of falling into the opposite extreme, and neglecting a remedy so potent, and oftentimes so beneficial, is, I think, imminent. Therefore, as one of the most powerful means we possess of controlling disease, blood-letting should maintain a prominent place in the list of remedies at the disposal of the physician for the amelioration or cure of "the ills that flesh is heir to." That it is too much neglected by the younger members of the profession, at least, of the present day, I think there is no doubt; and it has not been long since one of them, of considerable practice in this community, (and of which he is well deserving,) told me that he had not only never bled any one, but that he had never seen any one bled! With this impression, and with the hope of directing this portion of the profession to its

claims upon their attention, I have collected and condensed, from numerous sources, the views and experience of authors and practitioners respecting its employment in the various diseases in which it has been used, and have, also, occasionally given my own.

Some general circumstances should be taken into consideration in enabling us to determine the propriety of blood-letting. If the constitution is vigorous and tending to plethora, it will, of course, bear it much better than if feeble or anæmic. Age, also, should be considered; youth, or middle life, bearing it better than either of the extremes of infancy or senility. It is better borne by the sanguine than by the nervous or phlegmatic temperaments; by a person of temperate, than by one of intemperate habits. Climate and seasons should also influence, as it can be more freely resorted to in cold climates and seasons than in the warm. In the early stages of disease, as a general rule, it is more beneficial than in the later. In all that class of diseases in which the circulation is mainly affected, it is especially beneficial: as in plethoras; vascular irritations; inflammations; fevers; congestions, or sanguineous determinations; hemorrhages; or morbidly increased secretions or effusions.

In this paper, I shall briefly consider those diseases of the *nervous system* in which blood-letting is recommended.

In all accidental injuries of the brain or spinal marrow, blood-letting is frequently beneficial. In fracture of the cranium, concussion or compression of the brain, and hernia cerebri, venesection is required in many cases; and in all, except the last, arteriotomy may be necessary. In all of them, and in fractures or wounds of the vertebræ, local bleeding is beneficial, and venesection is sometimes required in the injuries of the spine and spinal marrow.

In *fracture of the cranium*, unaccompanied by depression of the bone, or by inflammatory symptoms, bleeding may sometimes be dispensed with; but, where these conditions make it necessary, the temporal artery should be opened, or a free bleeding from the arm resorted to.

Concussion.—In the first stage, or that of depression, bleed-

ing should be avoided; but when reaction takes place, then bleeding freely from the temporal artery or arm is requisite, one or two bleedings will generally suffice, and, if necessary, local bleeding may follow.

In *fracture*, or in *concussion* of the *spine*, where inflammation supervenes, leeches or cups should be applied along its track.

In all the phlegmasiæ of the brain, spinal marrow, and nerves, viz.:—in meningitis; cerebritis; tuberculous meningitis; cerebro-spinal meningitis (acute or epidemic); spinal meningitis; myelitis; or neuritis, both general and local bleeding are mostly indicated. In acute meningitis only, however, is arteriotomy proper; and, in this disease, when caused by hypertrophy of the left ventricle of the heart, bleeding should be more cautiously practised. In all these affections, general bleeding should be used the first few days, or until the severity of the symptoms abate, when cups or leeches may be substituted, until depletion is no more required. In all these affections, except cerebritis, we must be chiefly guided by the condition of the pulse, to determine the amount of blood to be taken: when the pulse becomes softer and slower, the bleeding to be checked, to be renewed when the exacerbation returns. But in *cerebritis*, the pulse is often, if not generally, small and corded, and the effect upon the brain, and system generally, must chiefly guide us as to the quantity drawn. If the pulse, when small and corded, rises under the operation, and becomes fuller and softer, it will, probably, be well borne. Frequently in this disease, and always in *tuberculous meningitis*, it is only in the *early stages* that venesection should be practised; to be followed, if requisite, by the frequent but moderate application of cups or leeches. In acute cerebro-spinal meningitis, it is equally called for; and even in the epidemic variety, or that improperly termed "spotted fever," it has been recommended by some authors; and I cannot but be impressed with the propriety of resorting to it in many of the cases that occur, judging by the symptoms related by those who have reported cases. It is true that I can give no experience regarding the treatment of this formidable malady, as it has never been my fortune, or misfor-

tune, to see a case; yet, it is my belief, notwithstanding the strong terms in which it has been denounced by some authorities, that this powerful agent is too much neglected, or too inefficiently used. When we take into consideration the symptoms—the disease being often ushered in with a chill; followed by severe headache; pains in the neck, spine, limbs; sensitiveness to light and sound; flushed, or turgid countenance; cramps, or spasm of muscles; opisthotonos; hot skin; great thirst; active febrile excitement; pulse, though sometimes depressed, often full and frequent; delirium; stupor; convulsions; coma; the temptation to me would be very strong to use the lancet, notwithstanding the symptoms of debility that eventually, and often speedily, supervene. It is true that, in many cases (as reported,) these symptoms, or the majority of them, do not occur, but a state of extreme debility or collapse prevails from the first; in such cases, depletion would certainly be improper. Only in the earliest stages of those with active inflammatory symptoms, probably, would bleeding be admissible, but the congested, and probably inflamed, condition of the brain and spinal marrow, strongly indicate its use in this stage. The rapid and overpowering influence of the disease, probably, soon induces the low or asthenic condition that supervenes, and if the inflammatory condition could be relieved, this result might not take place. I think these views may receive some support from a number of cases reported by Dr. C. G. PAGE, in the *EXAMINER* for October, 1865. He reports 19 cases, of which 3 recovered, and 16 died. They were all cases of males, generally in the full vigor of youth, "strong and healthy," and, in most of them, the symptoms before enumerated were present. In several of them the treatment is not mentioned, but in those where it was related, leeching was practised but once, and that with partial relief, and venesection not at all, and the natural inference is, that it was not practised in any case. As in cerebritis, innervation is often so overpowered by the condition of the brain as to depress the circulation, thereby causing a contracted, if not feeble, condition of the pulse, and, sometimes, coolness of the extremities, it is fair to infer that a violent

attack of cerebro-spinal meningitis may cause similar phenomena; and if in cerebritis the pulse often becomes fuller, or even firmer, after or during the abstraction of blood, so might, probably, a similar effect be produced by the same means in this affection. I present these views with diffidence, as they are not the result of experience. I know that most authorities regard this as essentially a blood disease; that there is a septic condition of the blood, with local inflammation of the base of the brain; or, that there is a dyscrasia in which the serum is rapidly separated from the crassamentum of the blood, producing serous apoplexy, or convulsions, or asphyxia, etc., according to the part of the body in which the infiltration takes place. All modes of treatment appear to have about equally succeeded (or failed,) and, therefore, basing my treatment upon the semeiology, I should be inclined to practice depletion in the early stages of those cases exhibiting active inflammatory symptoms, speedily following it with stimulants and tonics.

In neuritis, venesection, if the pulse is full and strong, and leeching along the course of the inflamed nerve is recommended.

In the *organic affections* of the brain and nervous system, bleeding has a beneficial influence. In hypertrophy, atrophy, or tumors of the brain, or spinal marrow, both general and local bleeding is sometimes called for; in abscesses of the brain, local bleeding only. In all this class of cases, venesection, when requisite, should be used with much more caution than in the preceding class; and in most cases, probably in all those of atrophy, as well as abscesses, should be confined to local bleeding. In the cerebral diseases, leeching or cupping the temples or nucha; and in the spine, over the affected part, would be the indications.

In sanguineous determinations, or congestion of brain or spinal marrow, bleeding, in some form, is very often required. In this class may be mentioned apoplexy; epilepsy; vascular, or passive congestion of brain; delirium ebrietatis; convulsions, and coma.

In *apoplexy*, general bleeding is usually indicated. In very urgent cases, arteriotomy may be preferable, but generally ven-

esection is sufficient. Though bleeding is generally requisite in apoplexy, it should not be indiscriminately practised, but the age and constitution of the patient, his general habits and health, and the causes producing the attack, should all be taken into consideration. Yet, I do not agree with some authorities, that we should be guided by the condition of the pulse alone, or always, in deciding upon the propriety of blood-letting. If the pulse is full and strong, authors advise bleeding, "but if small and feeble, there is no advantage to be derived from the further loss of blood at the commencement of the treatment." So says that eminent (and generally excellent and reliable) authority, Dr. WOOD, in his work on *Practice*, vol. ii., pp. 68, 69. But, as the attack is caused by hemorrhage or congestion, and the symptoms from either cause are generally undistinguishable, how are we to decide whether the compression from congestion does not still exist, thus, in a great measure overpowering innervation, and lessening the heart's action, and, consequently, the pulsation of the arteries? This is the view I took of a case some years ago, and I think the result justified it:—

One Sunday morning, about 10 o'clock, I was hurriedly summoned to one of my patients, a large-framed lady, of full habit, and upwards of 60 years old, several of whose family had died of apoplexy. Just as she was about to enter a place of worship, she fell, and was insensible. She was carried into a neighboring house, and, when I arrived, I found her sister, three physicians, and a number of her friends surrounding her. She was reclining on a sofa, with her feet in a hot mustard bath, and cold applications to the head. Her face (usually very florid) was pallid, but swollen; foam passing from her lips; her pulse *barely perceptible*. Her sister (a lady of great intelligence) earnestly besought me to do something for her relief; the other gentlemen probably fearing to advise blood-letting in the aspect of the case. I saw that death must speedily ensue if she was not relieved, and believing that hemorrhage might not yet have taken place, and that innervation was depressed by the congestion and compression of the brain, I laid my views before the three medical gentlemen, and received their full

approbation to resort to venesection; and, with the concurrence of the sister, to whom I explained, in few words, the case and its possible unfavorable result, I opened a vein in the arm, with one of the physicians with his fingers on one wrist, while I did the same with the pulse of the other. In a short time, there was an increase in the frequency and fulness of the pulse, and I then opened a vein in the other arm, and after the abstraction of probably twenty ounces of blood, and considerable reaction of the system, as shown by the improved condition of the pulse, the increased warmth of the skin, less dyspnoea, decreased stertor, etc., I had strong hopes of the recovery of my patient. In the evening she spoke, but not rationally; the next day she would answer questions, but in a confused manner until the evening, when she aroused to full consciousness, and four days from her attack was taken home, when she recovered her usual health. Two years before, she had had symptoms of an attack, which I warded off chiefly by a full bleeding. About two years after the second attack, and after my removal from the place, she died from the same disease. Now, if we had been guided by the pulse alone, as advised by Dr. Wood, who says, (p. 669,) "I would *repeat*, that the practitioner should be guided by the *strength* of the pulse, whether he shall bleed or not," and *not* have bled this patient, death must have inevitably and speedily occurred; and I think that the prompt and perfect relief given shows that the theory of depressed innervation from congestion, was, in this case at least, correct. On the other hand, I have had cases where the pulse was full and strong, the face red and turgid, and all the indications where bleeding is recommended, and who have, nevertheless, succumbed to the disease, notwithstanding free depletion; so that the pulse cannot always be taken as the guide for this practice.

In *epilepsy*, bleeding should be more cautiously used than in apoplexy, and should depend more upon the etiology than in the former disease. If preceded by meningitis, cerebritis, or cerebral congestion; or from injuries to the cranium, causing compression of the brain; or by a rich or plethoric condition of

the blood, especially if threatening apoplexy, venesection should be practised during the paroxysm; and if coma remains after the convulsive efforts cease, a repetition of the bleeding, or leeches or cups to the nucha or temples. The majority of cases, especially those of long standing, do not require it, and in many it would do much injury. Perhaps it would not be irrelevant here to remark that, in my early practice, I had an interesting case of epilepsy, the only *apparent* cause for which was thwarted affection. It was in a young lady, about 20 years old, of full medium height, and robust form and health. Her paroxysms were very violent, and bleeding and other remedies did not cure, though they ameliorated the severity of her disease. They did not recur very often, but were increasing in frequency. She was engaged to a young man, who was employed as supercargo in a vessel that sailed between our ports and the East; and, chiefly, on account of his seafaring life, her mother strenuously opposed her marriage. Connecting the period of the first appearance of the disease with that of her disappointment, and being unable to trace the cause to anything but the restraint she was imposing, from a sense of duty, on her strong will and desires, I thought it might possibly be that if this pressure (which *bleeding* could not remove) was taken off her brain and *heart*, she might probably recover; and, sympathizing with her in her trouble, I felt justified in stating to her mother, with considerable force and urgency, that I believed her daughter's convulsions were caused by the state of her feelings, and *her* opposition to her earnest and unsubdued affection. She was thus induced to reluctantly, to withdraw her opposition, and I was gratified, find that for three or four years (after that time I lost sight of them) subsequent to her marriage she had no return of them, and that she was blessed with a healthy child and a good husband. In her case, I have no doubt that the relief to her mental depression, and the consummation of her marriage, effected the cure; yet, taking her sanguine temperament, her tendency to plethora, and the severity of the convulsions into consideration, they might have proved fatal, had she not have been relieved by bleeding.

In *active* or *vascular congestion* of the brain, though not amounting to apoplexy, bleeding is generally required. If not subdued by venesection, then cupping or leeching the temples or nucha should be practised.

In *passive congestion*, or that caused by mechanical means, it is seldom requisite; where it is, local bleeding is generally sufficient.

Delirium ebrietatis is another disease in which the loss of blood may relieve unpleasant symptoms. I do not mean that condition of the system brought on in the habitually intemperate by abstaining from their accustomed stimuli, but the state caused by the stimulation of alcoholic liquors, in those not in the *habit* of intemperate drinking. In persons of a full habit, or sanguine temperament, an approach to congestion of the brain, or to meningitis, is sometimes produced by the too free use of liquors, when it becomes necessary to bleed.

In *delirium tremens*, it is, probably, never requisite; though there is sometimes a congested condition of the brain preceding the *tremors*, in which local depletion is required.

Coma, though but a symptom, or the effect of disease, may, from its importance, be treated of in this connection. If produced by congestion, or inflammation of the brain or its meninges, or by mechanical pressure, venesection, leeching, or cupping would be appropriate; but if from an anæmic state of the system, or from the prostration of fevers or narcotic poisons, it would be injurious. If the pulse is feeble, the skin cool, and the pupils dilated, bleeding can seldom or never be proper.

In the *convulsions* of children, connected with a full and frequent pulse, a flushed and swollen countenance, and hot skin, bleeding, either general or local, will frequently be required in the paroxysm; and if coma remains long after the paroxysm ceases, it may be repeated during the intermission. But a large number of cases will do well without it.

In *puerperal convulsions*, which are *generally* nearly allied to apoplexy, prompt and efficient venesection is called for, and, in some cases, even arteriotomy may be resorted to. Not only does bleeding unload the congested brain, by lessening the

quantity of blood in the body, but, in cases where delivery has not been accomplished, (and this is usually the case,) by its relaxing effect on the system, it causes the os uteri to dilate, and thus facilitates delivery. The pressure on the nervous system and on the circulation being thus removed, the chief cause of the convulsions ceases.

To the *functional* diseases of the brain and nervous system it is less applicable than to any of the classes mentioned, and in most of them may be dispensed with; and, when necessary, local bleeding is generally sufficient. In catalepsy, hysteria, nervous irritation, and cephalalgia venesection may be required occasionally, and with ecstasy, stupor, or vertigo may, more frequently, be treated by local bleeding.

Catalepsy.—In this rare disease, the pulse must guide us: if full and tense, venesection may be practised moderately, and cups or leeches applied to the temples or back of the neck.

In *hysterical convulsions*, where the pulse is full and strong, and the face flushed and turgid, blood may be taken from the arm. The causes of hysteria must, in a great degree, guide our treatment; but where there are local determinations of blood to any part, or where there is tenderness and irritation of the spine, local bleeding is often very beneficial.

In *nervous irritation*, when connected with a congested condition of any part of the nervous system, moderate *general* bleeding, or local bleeding may be advised; but it should be with great care, as the majority of cases do not call for it, and in many it would be very injurious.

Though *cephalgia*, like coma, is only a symptom of disease, and not the pathological condition itself, yet is of so frequent occurrence as to be a subject of interest, and its treatment of much importance. Though no doubt always symptomatic, yet there are cases, the etiology of which cannot be decided, and they are therefore termed idiopathic, for want of a better knowledge of the disease. In cases where there is determination of blood to the brain, or where the pulse is full, tense, or frequent, the head or skin hot, the eyes congested, or a secretion of tears, bleeding, both local and general, may be required, and will

often speedily relieve. Even in anæmic cases, there may be a congested condition of the brain from the impaired vigor of circulation; and I have known great relief obtained, in such cases, by the application of a few leeches to the temples. It is probable that in persons predisposed to plethora, a congested condition of the portal circulation is often the cause of severe headache, and that a free evacuation of dark, almost grumous, bile will relieve it. This I have a few times experienced in my own person, and I cannot account for the relief obtained, except on this supposition. In headache from this cause, bleeding may sometimes be necessary.

In ecstasy, stupor, or vertigo, local bleeding may often relieve the symptoms and prevent the accession of more serious diseases, of which they are generally the forerunners.

In some of those diseases of the nervous system, where one of the chief symptoms is deranged motion, bleeding, general and local, is sometimes necessary; especially in chorea, paralysis, and tetanus.

In the cases of *chorea* that have come under my care, I have never found it requisite to bleed, either generally or locally; and as it generally occurs in the young and feeble, and is often connected with an anæmic condition of the system, it will seldom be necessary, indeed, will generally be injurious to deplete. But there are cases in which local, and occasionally general, bleeding may have a beneficial effect; as, for instance, where there is a tendency to congestion of the brain, as indicated by a full and tense pulse, severe headache, and flushed features, leeches to the temples or moderate venesection should be resorted to; or if there is tenderness of the spine, cups or leeches should be applied to the affected part.

In *paralysis*, if caused by meningitis, cerebritis, apoplexy, congestion of brain, spinal meningitis, or myelitis, venesection, or local depletion, or both, are generally necessary in the early stages of the disease, but inapplicable at later periods, or when it has taken on the chronic form.

In *tetanus*, where there are symptoms of cerebral or spinal inflammation, as shown by fever, full and frequent pulse, head-

ache, tenderness of spine, and numbness of lower extremities, venesection and cupping over the spinal column should be practised; yet, many, perhaps most, cases of locked-jaw are produced by other causes, as punctured wounds, etc., in which there is no inflammatory condition of the nervous centres, and in which it is not required.

In *hydrophobia*, bleeding has, in some cases, been practised to, and with a view to, a fatal effect; but as to any *other* result, in respect to arresting or retarding the disease, we have not, that I am aware of, any reliable evidence. In regard to the moral or legal *right* that physicians have, to pursue such a practice, I think there can be no question. Their province is to *cure*, not to *kill*, and if they cannot effect the one result, they have no right to perpetrate the other. As well might we terminate the sufferings, by death, of our patients in any other terrible and generally hopeless disease, as in this.

There is but one other class of diseases of the nervous system to be treated of in this connection, and that is, those of deranged intellection.

In *insanity*, which comprises in its meaning the whole series of deranged intellect, general and local depletion is often called for; though, on this subject, authorities of great weight differ. In all cases of mania produced by cerebral inflammation, both theory and facts warrant us in employing venesection and local bleeding, promptly and freely. If caused by chronic phrenitis, or the puerperal state, more caution should be observed in the use of this measure, but it should not be neglected. If, however, it is to benefit the patient, it should be resorted to in the early stages of his disease; and though it may be serviceable even after insanity has been long confirmed, it is but seldom requisite. If in cases of insanity that have been a month or two under treatment there is not a marked amendment of the symptoms, the best practice the private physician can resort to, is to send his patient to a good asylum for the insane. This has been my rule, and I have not regretted it; for though one or two are yet lingering in hospitals, that were sent there fifteen years ago, by my advice, yet others have been released—some

partially, some wholly, cured; and in all cases, they have been more comfortable and better treated, professionally, than it would be possible for them to be at home, and by private practice.

I have thus given a sketch of the diseases of the nervous system in which this potent agent should, or may be used; and I scarcely need remark, that there are so many circumstances attending each individual case of disease, beside its *name*, to influence the decision of the practitioner in the treatment of his patients, that it is difficult to make any rule universally applicable, and on his knowledge and judgment must he alone depend at the bedside of the sick. Yet, the young and inexperienced physician may often be relieved of anxious and perplexing doubts, if he can avail himself of the opinions or experience of others; and, with this object in view, I have crudely and briefly treated of a portion of those diseases that may be benefited or relieved by this one of the agencies we possess, and which, if *properly* employed, is scarcely excelled in importance by any other. The subject will be resumed.

Chicago, February, 1866.

ARTICLE X.

SURGICAL CASES.

By GEO. K. AMERMAN, Attending Surgeon to the Chicago City Hospital.

CASE I. *Strangulated Femoral Hernia—Operation—Recovery.*

Miss G., aged 25, was attacked on Thursday, March 16th, with pain in the lower part of the abdomen, nausea, and vomiting. In the evening she took a dose of senna, prescribed by a friend, after which the pain and vomiting increased, so that, on Friday evening, Dr. HURLBUT, the family physician, was called. He at once recognized the true state of the case, and made a careful but ineffectual effort to reduce the tumor. The pain and vomiting continuing, I was invited by Dr. H. to see the patient, with a view of operating if the taxis failed after another patient

trial. At this time, the case presented all the usual phenomena of a strangulated femoral hernia. The tumor was not large, but firm and closely constricted. Dr. H. administered chloroform to complete anæsthesia, and we made an unsuccessful effort at reduction. A large dose of opium was ordered for the night, and the operation determined upon early the next morning.

Saturday, March 18.—No change in the character of the tumor or symptoms since yesterday. Vomiting and pain continue; bowels constipated from the first; pulse 96. Decided to operate, and, with the assistance of Dr. BOGUE, proceeded in the usual way to expose the sac. It was found unusually distended with dark-colored serum, and adhering to its walls everywhere, a loop of intestine perfectly black but glistening and firm. The stricture was divided, and the intestine left lying in the sac. A couple of sutures in the upper part of the wound, the remainder left open, with simple cold water dressings, completed the operation.

The opium treatment was adopted, and, after a very protracted convalescence, contrary to our expectations, the patient fully recovered, still being the subject of a small-sized reducible femoral hernia necessitating the constant use of a truss.

CASE II. *Strangulated Femoral Hernia—Operation—Death on the fourth day.*

Mrs. G., aged 66, for 26 years the subject of a large, irreducible femoral hernia, was taken on Thursday, May 18th, with vomiting, diarrhoea, and pain in the bowels. As such attacks were of common occurrence, her friends resorted to simple domestic means, and on Friday morning the vomiting and diarrhoea ceased, but the pain and tenderness continued.

On Friday evening, Dr. HURLBUT, the family physician, was called. He at once recognized the difficulty, and made an unsuccessful effort at reduction. On Saturday evening, I was invited by Dr. H. to see the case. She then had all the usual symptoms of strangulated hernia. The tumor was large, hard, painful, and dull on percussion. Pulse 100 and feeble.

It was decided to administer an anæsthetic, try taxis, and, if

unsuccessful, operate. Dr. H. administered chloroform to complete anæsthesia, and, after a patient trial to reduce, without the slightest effect, an incision was made through the external parts, the sac opened, and a large mass of omentum exposed. It presented a perfectly natural appearance, except, perhaps, rather more injection and less glistening. The stricture was divided and about two-thirds of the mass returned, the remainder left lying in the sac. A few sutures and simple dressings to the wound completed the operation.

The opium treatment was adopted, and everything progressed favorably until the morning of the fourth day, when she began to be delirious and show signs of prostration. Brandy, beef-tea, and quinine were given during the day, but she sank rapidly and died in the evening.

Remarks.—There are one or two interesting features connected with the above cases, which may be noted and made useful in future cases of a similar character. In Case I., strangulation occurred on Thursday, March 16th, and on Saturday, March 18th, at the time of the operation, the intestine was apparently gangrenous, though not softened; whilst in Case II., at the time of the operation, (the same time having elapsed after the occurrence of the strangulation as in Case I.,) the omentum was found almost perfectly natural. The symptoms before the operation were as urgent in the one as in the other, and, indeed, if external circumstances were any guide, we should have inferred a much more favorable condition of the parts in the first case than in the second. The age of the patient, the length of time the hernia had existed, and the size of the tumor were all favorable in Case I., and, hence, we believe, that in all cases of strangulated hernia, the operation should be performed early, without any regard to the apparent urgency of the symptoms. As soon as one careful, fair, and patient effort to reduce fails, where all the surroundings are favorable, the chances are that nothing short of an operation will save your patient, and the sooner that is resorted to the better are the chances of a successful result.

Secondly. The apparent condition of the hernial contents

cannot always be relied on in forming a prognosis. In Case I. the intestine was found quite black and, to all appearances, almost certain to slough, and yet the patient made a good recovery; whilst in Case II., although the omentum presented a perfectly natural appearance, death followed on the fourth day. The age of the patient, the length of time the hernia has existed, and the size of the tumor are all to be taken into the account, and, along with the condition of the contents of the sac, will enable us to form a reasonable prognosis in nearly every case.

ARTICLE XI.

MORTUARY STATISTICS OF NATCHEZ, MISS., FOR THE YEAR ENDING DECEMBER 31ST, 1865.

COMPILED BY J. STEBBINS KING, M.D., Surgeon in charge Mississippi State Hospital, Natchez, Miss.; late Recorder Board of Health.

EDITOR MEDICAL EXAMINER:—

I herewith transmit, for publication, a consolidated report or deaths occurring in this city, for the year 1865. It is compiled from the records of the Board of Health, and the City Sexton's books.

The Board of Health was organized by order of Gen. Davidson, in the latter part of last January, and continued to keep the mortuary records until the 14th of September, when the City Sexton resumed his duties under civil rule.

The number of deaths from unknown causes appears large, for two reasons:—First, there was no complete record of diseases kept during the month of January; Second, the physicians of this city, as elsewhere, are not as particular as they should be, in regard to reporting the causes of death to the City Sexton.

I am now compiling the mortuary statistics of this city from the year 1850 to date, which, when completed, I will forward to you. I am also collating, as rapidly as possible, the mortuary statistics of all the principal cities and towns throughout

the United States. And I would hereby request physicians to assist me, as far as possible, by forwarding me the mortuary reports of their several cities and towns, together with such topographical and meteorological accounts as may be of interest to the medical profession. As far as possible, I wish the reports to include the sixteen years from 1850 to 1865, inclusive. But where the mortuary reports are not complete for that length of time, forward such as are:—

	WHITE.		COLORED.	
	Male.	Female	Male.	Female
Apoplexy, -----	2	1	2	1
Abortion, -----	0	0	0	1
Angina Maligna, -----	0	0	0	1
Bronchitis, -----	1	0	0	0
Burned, -----	0	0	0	1
Birth, Premature, -----	0	0	0	1
Consumption, -----	6	7	3	5
Convulsions, -----	2	1	1	4
Congestion of Brain, -----	1	3	0	0
Cholera Infantum, -----	1	3	4	0
Colic, -----	0	0	3	1
Cancer of the Womb, -----	0	0	0	1
Croup, -----	0	0	1	2
Diarrhoea, Acute, -----	5	1	13	14
Diarrhoea, Chronic, -----	3	1	1	1
Dysentery, Acute, -----	1	2	2	8
Dropsy, -----	1	2	2	4
Dentition, -----	2	0	4	2
Drowned, -----	1	0	1	0
Debility, -----	2	0	0	1
Delirium Tremens, -----	1	0	0	0
Diphtheria, -----	2	0	0	0
Endocarditis, -----	2	0	0	0
Fever, Typhoid, -----	2	1	2	4
" Remittent, -----	1	2	4	6
" Congestive, -----	2	1	0	1
" Puerperal, -----	0	1	0	0
" Scarlet, -----	0	1	0	0
Gunshot Wound, (accidental) -----	1	0	0	0

Hydrocephalus,-----	0	0	0	1
Injury from a Fall,-----	0	0	1	0
“ of Spine,-----	0	0	1	0
Inflammation of Brain,-----	2	0	0	2
“ Bowels,-----	0	1	2	1
“ Heart,-----	0	2	0	1
“ Liver,-----	0	1	0	0
“ Womb,-----	0	0	0	1
Killed by Accident,-----	0	1	1	0
Mortification,-----	1	0	0	0
Measles,-----	3	2	2	3
Old Age,-----	0	1	1	1
Pneumonia,-----	5	1	13	4
Paralysis,-----	1	1	0	1
Rheumatism, Chronic,-----	1	0	0	0
Stillborn,-----	7	1	9	2
Small-Pox,-----	0	1	0	1
Tetanus, Traumatic,-----	1	0	1	1
Tabes Mesenterica,-----	0	0	1	0
Uterine Phlebitis,-----	0	1	0	0
Uræmia,-----	0	0	0	1
Unknown,-----	15	12	23	29
Whooping-Cough,-----	0	1	0	0
White Swelling,-----	0	0	1	0
Total,-----	75	53	99	108
Total of Whites,-----	128			
Total of Negroes,-----	207			

Of the 90 whites who died previous to the 31st of July, only 20 were of families of old residents; the remaining 70 being almost entirely refugees, who came here from the swamps of Louisiana, many of them dying within 48 hours after their arrival in the city.

The deaths for the several months were as follows: January, 27; February, 30; March, 26; April, 24; May, 52; June, 44; July, 34; August, 23; September, 18; October, 25; November, 17; December, 15.

The ages were—

Under 3 years,-----	118
Between 3 and 10,-----	43
“ 10 and 25,-----	43

" 25 and 40,-----	51
" 40 and 60,-----	29
" 60 and 80,-----	21
" 85,-----	1
Unknown,-----	29

The population of Natchez, as per census taken last spring, by the Board of Health, was:—

Whites,-----	3,558
Negroes,-----	5,026
Total,-----	8,574

Since that time, the white population has been considerably increased, and is probably at the present time not far from 5000; the colored population about the same. Thus Natchez now numbers about 10,000 inhabitants.

Estimating the average white population for the year to have been 4000, we would have a mortality of one to every 81½. And if we were permitted to deduct the 70 deaths of refugees, (who, properly, should not be added to our mortuary list, as, perhaps, without an exception, the diseases of which they died were contracted before arriving in the city,) we would have only one death to every 60 10-29 of the white population.

Estimating the average number of colored inhabitants for the year to have been 5000, we would have a mortality of one to every 24 32-207 of the colored population.

ARTICLE XII.

REPORT ON THE PREVALENCE OF DISEASES, &c., DURING THE MONTH OF DECEMBER, 1865.— BRONCHO-PNEUMONIA COMPLICATED WITH DI- ARRHŒA.—CEREBRO-SPINAL MENINGITIS.

Read to the Chicago Medical Society by N. S. DAVIS, M.D., &c.

During the first twelve days of December, the weather was dry, mild, and pleasant, with winds chiefly from the north and west. Then came a severe snow-storm, immediately followed

by seven or eight days of intense cold weather. About the 20th, the wind changed to the south, and it commenced thawing. It then continued warm and wet, the atmosphere being filled with mist and dampness, and the roads wet, until the evening of the 27th, when it again became freezing-cold, and remained moderately cold, clear, and dry until the end of the month.

Nothing unusual was noticed in regard to the prevalence of diseases during the first half of the month. Immediately following the extreme cold week that ended about the 20th of the month, catarrhal affections, consisting of slight inflammation of the mucous membrane of the nasal passages, fauces, and sometimes bronchial tubes, accompanied by rheumatic pains or general muscular soreness, became almost universally prevalent. Coincidentally with these simple catarrhal affections, there occurred an unusual number of cases of pneumonia and broncho-pneumonia of a very persistent character, and, in a large proportion of the cases, coupled with typhoid looseness of the bowels. The cases of broncho-pneumonia were much more frequent among children than adults, especially children under five years of age. It also prevailed most in the same parts of the city that presented the greatest prevalence of diphtheria and typhoid fever during the two preceding months. Many of the cases commenced with the ordinary symptoms of simple bronchitis, namely, frequent and harsh cough; soreness in the chest; slight general febrile action, generally increased at night; from two to four intestinal evacuations daily, usually thin, green, and sometimes mucous; with coarse mucous rhonchus all over the chest. After five or six days, the respirations would become much more short and frequent; the tongue and mouth more dry; the skin more hot and dry; the pulse more sharp and frequent; the cough shorter and more distressing; the child often giving a moan or grunt with each expiration; the mind dull and sometimes drowsy; the bowels more loose; the urine often scanty and turbid; and the chest, both anteriorly and posteriorly, at the lower part giving a well-marked sub-crepitat râle, and some dulness on percussion. These symptoms generally persisted from one to two weeks, giving the patient, during the

latter part of the time, a strongly-marked typhoid aspect, and then slowly declined, though many cases among the poorer classes of the people terminated fatally. In the cases of recovery, the convalescing stage was protracted and tedious.

During the same part of the month, there came under my observation four cases of cerebro-spinal meningitis, all in young persons; and an unusual number of cases of neuralgia, chiefly in the nerves of the face and neck.

During the last of the extreme cold days preceding the 20th of the month, I was consulted in regard to several cases of dizziness and a feeling of numbness in the head, in two instances amounting to temporary unconsciousness. All these cases were in persons who had been directly exposed to the cold, though, in some instances, very briefly. One, a female, past the middle period of life, had gone only one or two blocks, to a grocery store, and on her return fell unconscious in the street, from whence she was carried to her house, and in a short time recovered, though there remained a sense of confusion in the head when assuming an erect position for several days. No febrile reaction occurred in these cases. For several successive winters I have noticed similar disturbances in the functions of the brain in connection with extreme cold weather, especially in old people; and a simultaneous increase in the number of cases of convulsions and cerebral irritations in young children.

On the 27th of the month, the weather again became clear, dry, and moderately cold, and remained so until the end of the month, with a noticeable diminution of the catarrhal and pneumonic cases. The gross mortality for the month of December, as reported by the Health Officer, was 333; and for the whole year 1865, 3633; which, in a population of 180,000, would be equal to one death for every 49 inhabitants.

It should have been mentioned, that about the middle of the month of December, the water supplied for domestic use throughout the city, by the hydraulic works, became greatly impregnated with small fish, large numbers of which died in the water pipes, and, until past the middle of the succeeding month, kept the water so impregnated with the decaying fish as to ren-

der its taste and smell decidedly offensive. This was the only deviation from the usual local sanitary conditions of the city. Whether the use of such water had any influence in producing the persistent typhoid character presented by the principal diseases prevalent during that period, and in developing the few attacks of cerebro-spinal meningitis and erysipelas that occurred during the last part of the month, we leave each member of the Society to judge for himself.

All of which is respectfully submitted.

Selections.

CLINICAL LECTURE ON THE STUDY OF CHILDREN'S DISEASES.

Given in the Hospital for Sick Children. By CHARLES WEST, M.D., Physician to the Hospital.

GENTLEMEN:—A very wise and good man, to whom I owe much of whatever I have learned of my profession (Dr. Latham) makes, somewhere, the remark, that he was struck at the outset of his career with how, in a large hospital, knowledge was continually running to waste for the want of some one to gather it. He says, too, that this which struck him then, struck him even more forcibly in after years; the old experience, in short, "*Ars longa, vita brevis*," which is realized more and more as the shadows lengthen and the day goes down.

I feel it specially with reference to this hospital, because here, or in inquiries such as its wards suggest, my time, and thoughts, and energies have been engaged for the past twenty-five years, and I rejoice to see you here to-day, gentlemen, because in some of you I trust that I may find fellow-laborers—men already schooled by previous study, and who will be able as well as ready to gather, for the common benefit, some of that knowledge which will otherwise be but too likely lost.

But I am glad, also, to see others here, who as yet are but imperfectly trained, because, while they have much to learn, they have come here, to one of the best places in which to learn it, since disease may here be studied in its simplest forms.

It has been recommended by some, most fitted to give advice, that the student of medicine should begin with the diseases of the eye, since, through its transparent coats, as through a glass, the various processes of disease and recovery may be seen transacted, and "many of the little wonderful details in the nature of morbid processes may be learned, which, but for the observation of them in the eye, would not have known them at all." The ophthalmic wards of a hospital must, indeed, be revisited at a later period for the sake of the special knowledge to be obtained there, but they may well be visited at first for the elementary teaching which they afford.

Somewhat in the same way, you may come at two periods of your career to the study of children's diseases. *First*, to observe disease in its simplest conditions; then *later*, to investigate the peculiarities of symptoms which result from the tender age of your patients, and the modifications of treatment, which, on that account, may be required.

First, I said, to study disease in its simplest form. The chemist who analyzes a substance, submits it to various processes in order to remove from it all extraneous matters, and then applies to it tests to determine its real nature. This which the chemist does, however, is very difficult indeed, in the investigation of disease. Pure pathology is the doctrine of disease, unmodified by the intervention of disturbing causes from without or from within. To this in adult age we scarcely ever attain. The body, even in apparent health, yet tends imperceptibly to decay. We study disease in its influence on parts already damaged. The follies of youth, the vices of maturer age, the anxieties of business, the failure of hope, all leave their impress on the body, diminish its reparative powers, and render the different organs inapt to do their duty; so that almost all disease appears in a complicated, scarcely ever in a simple, form.

Care, too, which sits at the bed's head of the grown person, does much to retard recovery and to complicate disease. "Is your mind at ease?" said his physician to poor Goldsmith on his death-bed, observing how his pulse outbeat the frequency for which his bodily ailment would have accounted. In childhood there is little or none of this; no regret for the past; no dread of the future. The present is the world in which little children live; pain past is almost forgotten; and this mental tranquility contributes in no small degree to their recovery.

But I will no longer occupy you with insisting on things with which a little time spent here will make you quite familiar. I

will rather make a hasty survey of some of the cases which are now in the hospital, or which have been here so recently that many of you have had the opportunity of seeing them. I select them very much for the illustration they furnish of the unsolved problems which I want some of you to try to answer.

A little boy, aged 19 months, was admitted into the hospital, on the fourth day of an attack of pneumonia of both lungs. His respirations were 60; his pulse beat 148 in the minute. There was dulness at the base of both lungs, especially of the right; fine crepitation was heard below both scapulæ. I scarcely need add that the child seemed very ill. He was drowsy, but at the same time restless. He was very hot and his skin dry. He had some cough, but not very much. A mustard poultice was applied to the back and the chest. A little ammonia was given with small doses of ipecacuanha; beef-tea and wine for food.

In the night, the distress and restlessness were extreme until relieved by spontaneous vomiting; but on the afternoon of the fifth day the child was already better; the respiration had fallen in frequency to 44; and there was slightly improved resonance of the chest. Improvement continued. On the ninth day the respiration had fallen to 21, and the pulse to 124; percussion yielded an almost natural sound; and some largish crepitation was the only evidence remaining of the dangerous illness.

Now, here the recovery took place speedily and decisively, and in a way in which one could not refer it to the remedies employed. Nor is this a solitary case; it is one of many to which attention has of late years been especially called, which raise the question as to when and how far an expectant treatment may be adopted in inflammation of the lungs. It suggests to you the importance of determining the period of pneumonia at which spontaneous improvement is most likely to occur, the circumstances which in any given case justify you in expecting it, and those which, on the other hand, render its occurrence doubtful. Further, there remains the important question whether, though recovery would take place independent of treatment, it yet occurs sooner, or is more complete if treatment is adopted than if the case is let alone.

A girl, $7\frac{1}{4}$ years old, was admitted with the following history: Nine months before, she suffered from severe pain in her limbs, which yet did not constantly keep her in bed; but she was up every morning, and then as afternoon came on, grew worse, and went to bed. During much of this time her heart beat very

much, and at the end of a month, when the pains in her limbs had already ceased, she suffered so much from her heart that she was confined to her bed for six weeks. When better, she attended for some months as an out-patient, but six months after her illness began, her legs swelled, and her breath became short, and at length she came for admission here.

The heart's impulse was visible in the fourth, fifth, and sixth interspaces; the apex beat in the sixth interspace, one and a-half inch outside the nipple line. The upper dulness limit reached to the third rib, and the inner to a finger's breadth to right of the sternum. The oblique diameter of the heart was five and three-quarter inches, the transverse five, the longitudinal three and three-quarter inches; while, as you can now see for yourselves, there is a very manifest bulging of the whole heart's region. There was a prolonged wheezing systolic murmur heard at the apex, which diminished rapidly in loudness towards the base; the second sound was inaudible at the apex, but clearly heard at the base of the heart.

I am not going to trace this child's history in detail. She got relief from treatment, went out much better in three months, but soon came back in a state of great distress, for now pericarditis had come on. For some time she seemed likely to die, but once more got better, and you see her now, eighteen months after the rheumatism in which her sufferings began.

Now, here you have a case of heart disease, with enormous dilatation of the organ, succeeding to a comparatively slight attack of rheumatism. Each year adds to the child's sufferings, from which she will find rest only in an early grave.

Why is this so? Why does even a very small amount of valvular disease tend in some instances to produce a large amount of dilatation?

It is not an invariable occurrence. So little, indeed, is it invariable, that Dr. Latham notices the probable existence of some compensating power in the young heart, by which atonement is made for the effects of valvular disease: "a certain *protective* power possibly inherent in the growing heart, whereby it can accommodate its form and manner of increase to material accidents, and so suppress or counteract their evil tendencies."

But why is this sometimes? Why not always? Why not often? Is this happy issue rarer now than formerly, and if so, can it be that the change in practice which recent years have brought with them—the abolition of depletion, the disuse of mercury, have rendered the cure of rheumatic affections of the heart less complete than formerly? Or, is it only, and this I

apprehend to be the case, that our diagnostic skill and pathological knowledge have outstripped by far our therapeutical resources, that we discover the ills which we are impotent to cure?

A strong-looking, well-made girl, 10 years and 9 months old, began to suffer causelessly from chorea, three weeks before her admission into the hospital. There was no history of rheumatism in her family, nor had she herself presented any rheumatic symptoms, though there was a weak systolic bruit audible at the apex of her heart, which persisted, but did not increase, either in extent or loudness, during the whole of her illness. the choreic movements were at first limited to the left arm, but they increased rapidly, in spite of treatment, so that a month after admission the child was compelled to be placed in a bed padded all round, on account of the violence of her movements, while deglutition was very imperfect, and speech almost abolished.

She remained in the hospital for three months, at the end of which time she was almost well, and was sent into the country. She was submitted to very varied treatment, but without benefit, and her eventual improvement was spontaneous. For a time she improved in the country, but at the end of two months returned with a relapse of all her former symptoms, though their severity was far less than on the former occasion. In this instance, medicine seemed just as unavailing as before. The child began spontaneously to improve at the end of one month, was well at the end of two months, and has, I believe, since continued so, though the time is yet too short to feel sure of the permanence of her recovery.

Here, again, are several questions which await an answer. Why is the first attack of chorea almost always the most severe? Why is there no definite relation between the severity of chorea and the severity of the heart affection, and why is the heart sometimes quite unaffected, even though the chorea is very severe? Lastly, why is the heart affected at all, since the assumption of its rheumatic character, though true to a certain extent, is yet by no means always tenable?

Further, what clear indications can be laid down for the treatment of chorea besides the two furnished by the existence of constipation on the one hand, and anæmia or debility on the other, and the combined use of purgatives and tonics which they suggest?

Zinc and antimony, strychnine and belladonna, shampooing and sulphur baths have all been used in the treatment of chorea.

When is the one right, when the other, or in what combinations are they best employed? In what combinations? for I would not have you fall into the error into which the prevalent folly of homœopathy may imperceptibly lead you, of supposing that in order to act at all each remedy must be employed alone. He is the best physician, who knows best not only what remedies to use, but in what combinations; as the skilful general trusts not to his infantry alone, nor alone to his cavalry, but gains his victory most surely and most quickly by using different troops in combination; or,

"As many arrows loosed several ways
Fly to one mark."

Two more cases, and I have done for to-day. One is in the hospital now, the other recently left.

A boy, 8½ years old, was always a backward child, and while teething had three attacks of convulsions. Three months since he seemed causelessly languid for a fortnight; and then he was suddenly seized with vomiting. For six weeks together the vomiting returned daily or every other day. It was associated with an increased languor, and, by degrees, with drowsiness, and with pain in the occiput, which, though constant, became sometimes so severe as to make him scream aloud. A month after the commencement of these symptoms he was first observed to squint, and at the end of two months he had a fit which lasted for half an hour. In the ensuing month these fits returned six times. The vomiting ceased after the first fit, but the other symptoms continued, and became associated with pain on any movement of the limbs, and three weeks before his admission into the hospital it was first observed that his pupils were dilated, and that he had lost the power of sight.

He was a pale, thin child, with a peculiarly wretched expression of countenance; absolutely blind—his right eye looked straight forwards, his left inwards, and both were in a state of constant motion. He had complete power over his limbs. His headache was not constant; his appetite was good, and he did not vomit during the fortnight that he remained in the hospital. Nothing, however, seemed for a moment to amuse or please him, and he was allowed to go home, all the more readily, that his case was not one which held out much prospect of benefit from treatment.

What was this case? There was no family history of tubercle, nor did the boy present any appearance of it. Still the symptoms are not those of any acute inflammatory disease, and I should be disposed to imagine that they were due to the grad-

ual development of some tumor (and these tumors are almost always tuberculous,) which, arising at the base of the brain, had, by degrees, increased until by pressure on the optic nerve it had abolished the power of vision. And here it may remain stationary, though more probably it will continue to grow until it causes death, either suddenly by some outpouring of blood from the vessels at the base of the brain, or more slowly, by the production of inflammation, or effusion, into the ventricles consequent on pressure on the veins of Galen.

Here is, lastly, another case, somewhat obscure, indeed, but yet less so, I take it, than the preceding one:—

A girl, 8½ years old, whose father and two of her brothers had died with symptoms of brain disease, had suffered for a fortnight from troublesome cough, when she seemed unusually heavy, was attacked by violent sickness with headache, and sank speedily into a state of stupor, which continued with intervals, during which her mind wandered and she rambled in her talk, for 36 hours. At the end of this time consciousness returned, and the child sat up in bed, and showed some gleams of cheerfulness, but the pulse, which had been irregular during the state of stupor, still continued so, and the head was held somewhat retracted. Pain in the head and some retraction of it continued, though the child was well enough to be up, and moved about the ward.

She left by her mother's wish in a fortnight, and at the end of another fortnight she returned, much emaciated, complaining of pain which was now referred more to the ears than to the head, of pain also in the neck and in the right shoulder, towards which her head was inclined.

On this occasion she remained in the hospital four weeks. During this time she grew thinner and thinner, her skin became harsh, her abdomen retracted and tender to the touch, and her head was still drawn back as before. Auscultation now found the breathing weak everywhere, but especially so at the apex of the left lung, and percussion there was obviously dull. There was no vomiting, however. The bowels, once constipated, had now become regular, the complaints of headache were less constant, and the pulse had lost its irregularity. General tuberculosis was advancing; the mischief in the brain, I suppose, was stationary.

What is the import of this sudden development of the signs of cerebral disease, and what of their spontaneous passing into abeyance? If we could learn to answer these inquiries aright, we might possibly do something to arrest disease, even though

we were unable to effect its cure. Here, then, is another problem which I leave for your consideration.

But, say you, you came here to be told what I do know, and I have talked to you almost entirely of what I do not know, and that is not the object of a lecture, the purpose of which should be to impart positive knowledge.

Gentlemen, it is not quite so. The acquisition of knowledge implies an active, not a passive, state, and to this it was my object to excite you. It is when you seek, as for riches, and search, as for hid treasure, that you gain it; so, at least, said the man wiser than other men, and who himself wrote of all things, from "the cedar of Lebanon, to the hyssop that groweth on the wall."

You have come to the study of medicine, furnished far differently from those who, like myself, entered on it more than 30 years ago. It is but right that you should turn these advantages to good use. We are, indeed, as has been well said, like people standing together on a hill, which I have climbed before you, and I, to whom the landscape is in some measure familiar, may say to you look here and look there, and you will see this and that. But further, I say to you, the objects there are indistinct to me; but you have perspective glasses of higher power than mine; turn them in this direction or in that, and you may, with patience, discern clearly what I can see but partially, or, with my imperfect instrument, perhaps cannot see at all.

If you visit the wards of this hospital, I may, too, do some of you the service, that I may point out to you what is worth the seeing, and may help to guard you from the dangers of the young student—that of playing with the instrument itself, vain, perhaps, of his dexterity in its use, or of turning it thoughtlessly on trifling things not worth the investigation.

You must not forget that it is your duty, as it is mine, to map out the country for the use of yourselves and of future travellers, to seize its great features, which may serve as landmarks, and not to waste your time on some quaint tree or curious rock which lies quite out of the path along which you have to journey.

"*Nisi utile est quod agimus vana est gloria nostra*," should be your motto, though in a different and lower sense, indeed, from that in which it was employed by the inspired penman some eighteen hundred years ago.—*Med. Times & Gaz.*, Oct. 28th, 1865, and *Phila. Medical News*.

REPORT OF THE COMMITTEE APPOINTED TO MEMORIALIZE CONGRESS IN REGARD TO THE MEDICAL DEPARTMENT OF THE ARMY.

CINCINNATI, OHIO, May 9, 1865.

The undersigned of the Committee appointed by the American Medical Association to memorialize Congress in regard to the passage of a law for the Medical Department of the Army, and to present the draft of such a law to each Senator and Representative, have the honor to report:—

That they took the subject immediately into consideration, but that the time they could command was too limited to enable them to prepare a memorial and draft a law before the adjournment of the session of 1864 and 1865. After an interchange of views among the members of the Committee, necessarily conducted through the mails, a memorial and draft of a law were agreed upon by the majority of the Committee, printed and distributed as directed by the Association, at the commencement of the last session of Congress. This memorial and draft of a law were in the words following, to wit:—

To the Senate and House of Representatives of the United States:

The undersigned, a Committee appointed by the American Medical Association, at a meeting held in the city of New York, in June, 1864, to memorialize your Honorable Bodies in regard to the passage of a law for the better organization of the Medical Department of the Army of the United States, in the discharge of the duty imposed upon them, respectfully represent—

That if the experience of the previous wars in which the country has been engaged had not been sufficient to indicate the importance and necessity of clothing the medical officers of the army with an absolute military rank, that should settle their authority to execute their own functions unquestioned by officers of other branches of the service, the magnitude of the present contest, and its all-pervading interests, have, in their opinion, forever determined this fact. The necessities of present circumstances have forced upon medical officers the exercise of military functions and command, without and even against the authority of law, in some instances, but which is absolutely indispensable to the existence of a Hospital Department. The Act of February 11, 1847, which first conferred military rank upon medical officers, expressly forbids them to exercise military command in the line, or another staff department. Still from necessity, and in obedience to the orders of the Secretary

of War, they now exercise such command, and that under General Orders No. 212, July 9, 1863, emanating from the War Department.

Surgeons in charge of general hospitals are and must be the commanding officers thereof. They are responsible as well for the discipline and administration of those establishments as for the medical and surgical treatment of the sick and wounded. From the nature of the case, none other than a medical officer can discharge these strictly military duties, and wherever an attempt has been made to divorce the military and professional functions in a general hospital, the result has been conflict of opinion and authority, discontent, altercation, and paralyzed efficiency.

Were the claim to an effective and indisputable rank for the Medical Department novel in principle in our service, it might be plausibly controverted; but when the propriety and advantage of such rank in staff departments have been so completely settled, as they have been by the examples of the Quartermaster's and Subsistence Departments, it cannot now be successfully refuted.

Brought into immediate contact with, and exercising the immediate control over thousands of soldiers, charged with the care of their pay, subsistence, clothing, and discipline while in the General Hospitals, the Medical Department alone is assimilated in functions to the officers of the line, and is *de facto* compelled to exercise military command over the persons of soldiers, and whatever of failure there may have been to meet the full requirements of their duties in these respects, is, in our opinion, distinctly to be traced to the defenceless position in which they are left in regard to the interference of other officers possessing the immense advantage of unqualified military rank, with their own management of their own departments.

The grade of the medical officer in command of a general hospital should, in our judgment, never be less than that of a field-officer. Many of these establishments contain more than one thousand soldiers, some of them more than three thousand, a command equal to that of a brigadier-general. The medical directors of armies and military departments have only the rank of majors, and even this restricted, while the chief quartermasters of the same are invested with the unrestricted rank of colonels—the latter exercising no command over soldiers, while the former have from ten to twenty thousand military persons under their control. They are at the same time responsible for the careful and economical distribution of vast amounts of pub-

lic property, and without the experience and ability in this special department, which long and careful training alone can give, the money value of the loss of life which would result would certainly equal the expenditures of the Quartermaster's Department, vast as they are. With at least equal responsibilities, and equal zeal, and equal devotion, the medical officer is denied an equal rank with the quartermaster, and even the limited rank which is conceded to him, is so clogged with restrictions as to be of little avail for the public good.

We, therefore, pray your Honorable Bodies to give these evils your serious consideration, persuaded that the result will be such a remedy as will satisfy the claims of equity, of justice, and of the best interests of the service.

The Committee having been further instructed to prepare a bill for the consideration of Congress, and to "embrace in its provisions a further separation of the Medical Department from the Commanding Officers of the Line, in order to have a more perfect and unrestrained control of its interests and greater efficiency in that branch of the service, in the fulfilment of this duty, beg leave to present the following sketch of such a bill as they think would meet the views of the American Medical Association, and secure the objects they desire:

1. The Medical Department of the Regular Army shall consist of—

One Surgeon-General—Brigadier-General:—

One Assist.-Surg.-General—Colonel

One Purveyor-General—Colonel

One Inspector-General—Colonel

Twelve Staff Surgeons—Lieut.-Colonels

} of Cavalry:

One Surgeon (Major); one Assistant-Surgeon (Captain), and one Assistant-Surgeon (1st Lieut.) for each regiment of Artillery, Infantry, and Cavalry, for the Ordnance and for the Engineer Corps:—

2. For the Volunteer Army whenever called into service:—

One Assist.-Surg.-General, one Purveyor-General, and one Inspector-General: Staff Surgeons as many as are necessary for the command of the General Hospitals, with the same rank as the same officers in the regular service:—

One Surgeon (Major), one Assistant-Surgeon (Captain), and one Assistant-Surgeon (1st Lieut.) for each Regiment of the Line actually in service.

Candidates for the appointment of Assistant-Surgeon shall be examined by a board of not less than three Medical Officers of their own branch of the service.

A second examination by a similar board shall be required for promotion to the rank of Major.

General Hospitals and their Guards shall be under the command of the medical officer in charge, subordinate only to the commander of the Department or Army in which they are located.

A Hospital Corps, consisting of companies of sixty men each, shall be organized as companies of Infantry for duty as nurses, cooks, and guards to General Hospitals.

Promotions in the Medical Department of the Regular Army and volunteers shall be made in accordance with the principles that govern in other departments of the respective forces.

The Medical Director of an army in the field or a Geographical Military Department shall have the local rank of Colonel of Cavalry.

Medical Purveyors of principal Depôts (Surgeons in the regular Army of Volunteers) shall have the local rank of Colonel of Cavalry.

Physicians employed by contract shall have the local rank of 1st Lieutenant at the Hospitals or Posts where employed.

All acts or parts of acts inconsistent with this act are to be repealed.

We have the honor to be, very respectfully,

Your obedient servants,

(Signed)

CHAS. S. TRIPLER, M.D.,

CHRIS. C. COX, M.D.,

FRANK H. HAMILTON, M.D.,

D. L. MCGUGEN, M.D.

In preparing this memorial and draft of a law, your Committee found it difficult to reconcile conflicting views and interests, the natural result of the distinct organizations, regular and volunteer, then in the service. They did not think that a law applicable to the then existing state of the department only, would fulfil the expectations of the Association. What was wanted was a plan for a permanent and not a merely temporary organization; a plan capable of being contracted to the limits of a peace establishment, still preserving its integrity, and, at the same time, of being instantaneously expanded sufficiently to meet the requirements of an army large enough to carry on any war in which the United States may hereafter be engaged.

It is evident that in time of peace, none other than regular troops can compose the army of the United States—it is equally evident that in time of war the greater portion of the troops in

service must be composed of volunteers. If a plan had been proposed to merge the medical departments of the two descriptions of troops into one, and if such plan could be successful, it is plain that upon the reduction of the army all would become regular again, and upon the next occasion the distinction would be renewed and its conflicting interests and antagonisms, if they exist, must inevitably be revived.

The great objects of your Committee have been, first, to provide a medical staff for the land forces of the United States adequate to any emergency that may arise; and, second, to clothe the officers of that staff with a military rank that would forever settle the question of their subordination to officers of inferior rank in the other branches of the service.

Previously to the breaking out of the rebellion, the largest armies we have ever set on foot were insignificant in comparison with the enormous hosts that have been kept in the field for the last four years. For the last fifty years, with the exception of the Mexican War, the United States may be considered to have enjoyed uninterrupted peace. Our small force was distributed in scattered posts over the vast surface of the country, in detachments so small as to require little of a medical department beyond the mere prescribing for a dozen men daily at a post hospital. The military mind of the country could perceive no necessity for any military authority being conferred upon a medical officer, and this mind had indolently and thoughtlessly drifted into the idea that such an authority was preposterous and absurd. The school of the last four years has, however, done much toward dissipating this delusion. The wise and thoughtful, particularly in the higher grades, no longer cling to this mouldy fossil, and the present Secretary of War, by conferring brevets upon several medical officers, both regular and volunteer, and the Congress of the United States by enacting a law conferring the unlimited rank of colonel and lieutenant-colonel upon medical directors, has settled the principle that the medical staff is a military branch of the service, equally with the quartermaster's and subsistence departments.

The medical profession owes much to the Hon. E. M. Stanton, Secretary of War, for the several orders he has issued and enforced, conferring the independent command of the general hospitals upon the surgeon in charge, and placing under their command the officers and men constituting the Second Battalion of the Veteran Reserve Corps, thus removing a military disability from medical men, as fatal to their efficiency as it was insulting to their self-respect.

But the laws in reference to the present organization of the medical department of the army, with the exception of that in relation to medical directors, expire by their own limitation with the present war; when the country is declared pacified, things revert to their *status ante bellum*, and without further legislation, the people and armies of the United States are doomed again to encounter the confusion and disappointments necessarily consequent upon the entirely inadequate organization of the medical department for a state of war.

By attending to this matter now, and by making suitable provisions for a medical department, susceptible of expansion to meet every emergency, this confusion and disappointment may be avoided, our troops always provided with a competent hospital establishment, the mode of appointment of medical officers fixed by law, and not left to the caprices of politicians and the chances of a ballot, and thousands of lives and millions of money saved to the nation.

By leaving the question of organization unsettled during the approaching interval of peace, which God grant may be a long one, we are certainly doomed to incur, upon the breaking out of another war, the same evils that have marked the inception and progress of this, and we shall require a repetition of the same severe lesson of suffering, to educate once more the military mind of the country up to a point that will induce it to yield a tardy and reluctant assent to the now patent fact—that the medical department is as essential to the organization of an army as the engineers, and that an efficient medical department cannot exist without a recognized military position. With these views your Committee would be insensible to the teachings of the past and to your just expectations, if they should fail to urge upon the members of the American Medical Association their earnest recommendation that, as an Association, they shall reaffirm their convictions of the necessity for immediate legislation in reference to the military rank of the medical department, and as individuals each shall pledge himself to use all honorable influences with the Representatives of their several Congressional districts, and the United States Senators from their States, to induce them, at the next session of Congress, to enact the law sketched out in the draft of your Committee, or some other law based upon the same fundamental principle.

All of which is respectfully submitted.

CHARLES S. TRIPLER, M.D.,
CHRIS. C. COX, M.D.

THE AMAUROSIS AND DEAFNESS OF SMOKERS AND DRINKERS.

By MM. SICHEL AND TRIQUET.

Annales d'Oculistique, Mars; and Gazette des Hopiteaux.

M. Sichel, in continuation of a former communication published in 1863, observes that among the forms of cerebral amaurosis there are two which, although little known, are not of infrequent occurrence, and are difficult of cure. One of these, produced by the abuse of alcoholic drinks, he described as long ago as 1837, under the designation of "amaurosis symptomatic of delirium tremens;" and the other, produced by the abuse of smoking, was first described by Mackenzie. Incredulous, as to this last, when first announced, M. Sichel, in the course of 28 years' practice, has frequently met with it, and he believes that there are few persons who can smoke for any long period more than five drachms of tobacco daily, without their vision, and often their memory, becoming affected. In both these forms of amaurosis there is well-nigh absence of all well-marked cerebral congestion, and there is a vagueness in their sthenic or asthenic characters, which may cause hesitation and perplexity on the part of the surgeon, if unaware of the cause in operation. The ophthalmoscopic appearances, as in most old cerebral amauroses, are negative or ill-marked. The optic papillæ, sometimes very white, especially in one of their halves, sometimes slightly injected, have their contours ill-circumscribed or in part effaced. The retina is but little injected, the central vessels being sometimes normal and sometimes enlarged, the central veins being especially so when the affection has reached its last stage. All the characters observed are, in fact, in common with those of other cerebral amauroses. As in many of these, too, the memory is often enfeebled; and in the amaurosis from alcohol there are frequently trembling of the hands in the morning, and at a later period morning vomiting. Both of these varieties are very slow in their progress toward cure, and very refractory to treatment. Usually observed separately, they may be seen together, and in such cases it is not easy to decide whether the tobacco or the alcohol plays the chief part. The treatment of these cases usually occupies a long time, and an essential point, of course, is the discontinuance of the practice that has given rise to the amblyopia or amaurosis. In the few cases in which there is any marked congestion present, this must be met by anti-

phlogistics; but when this is not very positive, bleeding must only be resorted to with the greatest care. As in all forms of passive or old cerebro-ocular congestion, liberal depletion, even by leeching or cupping, and still more even moderate bleeding, soon completes the loss of vision, and this is only slowly and incompletely restored. On the other hand, external and internal stimulants, such as liniments, flying blisters, camphor, strychnine, etc., resorted to before a moderate antiphlogistic and derivative treatment has been put into force, only aggravate the disease. When there is but little congestion, mild aperients are very useful, such as equal parts of cream of tartar and magnesia, alternating with pills of gum ammoniac, sulphate of potass, and aloes. In drinkers these means will not be borne, and minute doses of rhubarb and magnesia may be substituted. Cold water should be applied to the forehead and eyes, while the lower extremities are irritated by sinapisms, dry cupping, etc. At a later period are indicated stimulant liniments to the circumorbital region, flying blisters, first to the nape, or behind the ears, and then to the temples; and, in very obstinate cases, the various internal stimuli, as camphor, arnica, strychnine, etc., may be tried.

M. Triquet states that in smokers and drinkers an insidious and obstinate form of otitis frequently becomes developed. There is a kind of numbness or torpor of the ear, with a sense of cold, but rarely any pain. There is no cerumen in the meatus, the membrane and ossicula are in a normal state, and there is little or no vascularity. There is, however, extreme dryness with very minute granulations of the pharynx, nasal fossæ, tubes, and middle ear. Frequently both ears are affected, but one has always commenced being so before, and is more deaf than the other. The deafness, without being very troublesome at first, rapidly increases. Noises in the ear almost always exist at an early period, and it is of importance to notice that they assume a hissing sound. The affection exhibits itself in three periods:—1, that of excitement, in which there is intolerance of noise, and a hissing noise in the ear; 2, that of depression, in which the hissing sound disappears, or only remains as a distant and feeble echo; and 3, that of a paralytic condition of the auditory nerve, in which the sense of hearing is more or less completely, and often permanently, lost. In this period there are also often trembling of the tongue, embarrassment of speech, and disturbance of vision. The prognosis is very unfavorable, for those patients alone are susceptible of cure who will consent to leave off the bad habit which has produced the affec-

tion. For treatment, in the very early stages, cupping of the mastoid processes and drastic purgatives, and then alteratives, as calomel, sulphur, and small doses of arsenic, are indicated. Locally stimulating fumigations, and weak injections of strychnine or veratrine have proved useful; electricity has always done harm.—*British & For. Med.-Chir. Review, and Dental Cosmos.*

BLEPHARITIS CILIARIS AND PHLYCTENULAR CONJUNCTIVITIS.

By E. WILLIAMS, M.D., Professor of Ophthalmology, and Aural Surgery, Miami Medical College, Cincinnati, Ohio.

It is not my purpose to give a lengthy description of these common and well-known diseases, but to call your attention to some practical points in their treatment. Still a hasty sketch of their characteristic features will facilitate a better appreciation of the therapeutic measures which I wish to present. Whether associated, or existing separately, blepharitis ciliaris (sometimes called blepharitis marginalis—bleparadenitis—tinea tarsi) and phlyctenular or pustular conjunctivitis occur usually in early life and in the same class of patients. The period of life at which they are most frequent is from the second to the fifteenth year. If they are seen after that age, it will generally be found to be but a continuation of the same affection from an earlier period. Children of a strumous or scrofulous diathesis are the almost exclusive victims of these maladies.

Strictly speaking, blepharitis ciliaris, as the name intimates, commences in the individual follicles of the eyelashes, and invades the other textures of the lids subsequently. It is an inflammation of those follicles followed by little abscesses, of which the cilia form the centres. These minute collections of pus become confluent along the edge of the lid, agglutinating the lashes in little tufts, and forming scabs or crusts as they desiccate. These adhere very firmly, and when removed forcibly, produce pain, often bring away some of the hairs, and the surface beneath is found to be raw or ulcerated—perhaps bleeds. These patches of disease may be limited, or extend the entire length of the lid. When this local difficulty has lasted for some months or years, the bulbs of the lashes are gradually obliterated, the hairs fall out, grow in a stunted form, or cease altogether; giving rise to that thickened, red, perhaps partially everted state of the edge of the lid, called *leppitudo*.

Blepharitis ciliaris, when once well established, usually persists for years, or for the remainder of life if cleanliness and favorable hygienic measures are impracticable or not enforced. The amount of redness, swelling, and soreness of the lids varies very much under special provocations or favorable circumstances. The smouldering fire at the roots of the lashes, however, never ceases; and that is the focus from which they flame out. Intercurrent attacks of phlyctenular conjunctivitis often complicate and aggravate the difficulty; and not very unfrequently, in the chronic forms, there is set up blennorrhœa of the lachrymal sac, with its consequences. On the contrary blepharitis marginalis may, in its turn, be provoked and perpetuated by dacryocystitis, stricture of the nasal duct, and dilatation of the sac. Now these conditions mutually aggravate each other, and the necessity of embracing them all in the treatment is self-evident. Eczema and other eruptions about the face and head, and especially in and around the nostrils, causing a constant running, with redness and thickening of the nose, or the formation of scabs, are likewise a very frequent and troublesome complication.

Phlyctenular conjunctivitis (often called scrofulous ophthalmia), is marked by symptoms so peculiar as not to require a tedious description. It is a partial inflammation, commencing in the conjunctiva of the globe, and attended by pustules or vesicles. These so-called phlyctenulæ are most commonly seated on the line of junction of the cornea and sclerótica, but sometimes they are seen entirely on the one or the other of these structures. They are inflammatory accumulations of serum or of pus under the epithelial layer of the conjunctiva, and when located on the cornea are designated phlyctenular keratitis. These may be absorbed without rupturing, but generally the elevated epithelium bursts and leaves superficial ulcers, called on the cornea, facettèd ulcers. In favorable cases they then heal, by being first covered with a new epithelial layer, that makes them appear shiny and smooth in the bottom, and a subsequent reproduction of the deeper layers. On the cornea they leave little circular depressions, readily seen by looking obliquely at them, which persist a very long time before they are filled to a level with the general surface. If the ulcer extends deep into the lamellæ of that membrane, permanent, or at least long persisting, white specks or opacities are left behind. When situated towards the centre of the cornea, and a bundle of vessels develops under the epithelium, running from the conjunctiva scleroticæ to the pustule, lymph often exudes in a nar-

row strip along the course of the vessels, leaving a concentric opaque streak in the cornea. In some cases, on the other hand, a series of vesicles following from the margin towards the centre, are produced, attended by the gradual pushing forward of the little loops of vessels, and leaving when they subside the same riband-like opacity just mentioned.

So long as the phlyctenulæ are confined to the conjunctiva scleroticæ, there is seldom any marked intolerance of light or other suffering. But when they come out on the cornea, especially if near the centre, they nearly always give rise to extreme photophobia, profuse lachrymation, and sometimes severe pain. The intolerance of light is so intense often, that the little sufferers seek the darkest corners, lie on their faces and bury their eyes, covered with their hands, in a pillow or anything they can get, so as, if possible, to exclude every ray of light. This confines the perspiration, heats the eyes, aggravates the eruptions of the face, and is in all respects the most distressing symptom, lasting frequently for weeks together before any light can be endured. This feature of the disease is more marked in the morning, giving way towards evening, so that after sundown the child may open its eyes better. This excessive tenderness to light, resulting in reflex, spasmodic contraction of the orbicularis palpebrarum, and profuse lachrymation, is the result, in my judgment, exclusively of irritation of the corneal filaments of the fifth pair of nerves. Whenever I see these delicate, scrofulous children, with their eyes covered and spasmodically closed, I am certain that they have corneitis with little specks or ulcers. Still I always insist on holding the child's head between my knees, with its face up, and forcibly opening and examining the eyes, so as to see the exact state of the cornea. This is less cruel and also less *irritating to the mother*, than plunging the child's face in ice-water, as recommended by Graefe, and others.

In extreme cases chloroform may be used, but I seldom find it necessary. The photophobia is frequently out of all proportion to the amount of local trouble; but there is always some deposit in the cornea, or abrasion of its surface, which can be detected by a proper inspection.

It is comparatively seldom that these phlyctenulæ give rise to ulcers that invade the deeper layers of the cornea; but sometimes this occurs. The edges and bottom of the ulcer then become infiltrated with a dirty-white or yellowish-colored deposit, which, as it goes deeper and deeper, becomes complicated by hypopium, and eventually, if not properly treated,

results in perforation and prolapsus of the iris. This tendency to deep ulceration and perforation of the cornea in pustular conjunctivitis, is sometimes epidemic. A few months ago, some seventy or eighty children in one of our neighboring orphan asylums, were attacked within a few days with this disease. Rapid ulceration, hypopium, and perforation took place in many of them, and several were blinded in one or both eyes before any treatment was thought of. Some of them had had granulated lids previously, and some had not. The affection assumed the form of general catarrhal conjunctivitis, with large sloughing phlyctenulæ, which were not influenced by anything but repeated paracenteses of the cornea, atropine, and compression with cotton and an elastic bandage.

In the treatment of this class of diseases I have used for the last eight years a preparation, not found in any of our books, which is so uniformly and promptly beneficial, that I have abandoned all the other mercurial local applications in its favor. When *opportunately* and properly applied, it acts like a charm, and patients or their friends nearly always come back, if they ever have another attack, and ask for some more of that *brown salve*. The formula for its preparation, I found in a foot-note in an old edition of Wilde on the Ear. He recommended its use very highly in chronic diseases of the dermoid lining of the meatus auditorius externus. It occurred to me that its peculiar properties might prove useful in the diseases under consideration. I tested it extensively and faithfully, and it has far surpassed my most sanguine expectations. I call it the *brown citrine ointment*, and write it *Unguent. citrin. rub.* At my request, Mr. A. Fennel and Prof. E. L. Wayne, well-known chemists and druggists of this city, have experimented in making the ointment till they have very much improved its quality. The original formula was the same as that of the U.S. Pharmacopœia for the preparation of citrine ointment, excepting that cod-liver oil was substituted for the axungia and the neatsfoot oil. Still it was somewhat granular and coarse, till Prof. Wayne finally succeeded by *reheating*, and then stirring till it was cool, in making a dark mahogany-brown salve of uniform consistence, tenacious, and readily melting with the temperature of the body. When rubbed on the lids or applied to the conjunctiva, it melts in a few seconds, spreads and adheres a long time to the lids; or, if used in the eye, is rapidly diffused over the ball by the movement of the lids, with *very little irritation*. It can be used in its pure state, and does not need to be removed afterwards at all. My treatment for ble-

pharitis ciliaris is very simple. The first thing on which I always insist, and without which no treatment does much good, is to keep the edges of the lids *absolutely free from scabs or scales*. I have the eyes bathed with tepid water morning and evening, till the scabs are soft and can be readily scraped off, or rubbed off with a soft rag. If there is much rawness and soreness of the margins of the lids, I trim off the lashes with a fine pair of scissors, as close as possible. This is much better than pulling them out, as recommended by some authors; and when so trimmed, it is much easier to keep the lid free of scabs. If the lids are swollen and very sore, I have them poulticed every night for a few days; and sometimes when there are ulcers or raw places along the roots of the lashes, I touch them lightly for a few times, at intervals of two or three days, with a point of nitrate of silver. Every night, after the washing and cleaning, the salve is rubbed well along the edges of the lids with the finger. If it irritates and causes the skin to puff up and look redder next day, which it rarely does, the patient may omit the use of it the next night; otherwise, it should be applied every evening at bedtime. Its continuance two or three times a-week for several weeks or months after the disease is entirely relieved, should be urged, to prevent a relapse. If there is much conjunctivitis, I prescribe a solution of four grains of sulphate of morphia, and half a grain of sulphate of copper or zinc, to the ounce of water, dropped into the eye three times a-day. Internally, such patients should always take iron or tonics of some kind. I usually gave the liquor ferri iodidi, in doses suited to the age of the subject, and keep it up for several months, to secure a *radical result*. Of course, regular exercise in the fresh air, good nourishing diet, bathing followed by friction, and the avoidance, as far as possible, of all causes of irritation, are important hygienic measures in this class of diseases.

In phlyctenular conjunctivitis where the vesicles have their seat on the conjunctiva scleroticæ, or being on the cornea, give rise to but little intolerance of light and lachrymation, this salve again is most valuable. A portion of it, say a small drop, should be put from the end of a knitting-needle or probe, between the lower lid and the ball and the upper lid, then moved up and down a few times till it is spread freely over the cornea. This ought to be done at bedtime. The larger portion of the salve is soon washed and pressed out on the edges of the lids, and, if blepharitis exists, can be usefully rubbed along the margin; otherwise it may simply be wiped away. If the conjunctivitis is more general, and there is much mucous secretion, I direct

the astringent given above; otherwise, the ointment alone suffices perfectly.

Phlyctenular corneitis is treated in the same manner, when the acute symptoms have begun to abate, or when it assumes a mild form from the start. If there is marked dread of light, spasmodic closure of the lids, and epiphora, a few days of preparatory treatment are necessary. For the relief of the photophobia and other symptoms arising from acute inflammation of the cornea, there is nothing equal to the local application of a solution of atropia. In a child from two to five years old, I prescribe a solution of gr. j. to aquæ ʒj., to be dropped into the eye from three to six times in the twenty-four hours, according to the intensity of the symptoms. If they are over five years old, a two-grain solution may be directed. Internally, the sulphate of quinine in very liberal doses, say from one to two grains, even more where the photophobia is extreme and obstinate, three times a-day, with the solution of sulphate of atropia locally, nearly always overcomes these distressing symptoms in a few days. If the quinine alone does not subdue the intolerance of light, I combine opium with it, giving from half a grain to a grain with the quinine three times a-day. Under this treatment, the child begins to open its eyes and bear the light better in a short time. It is astonishing what effect the atropia has in quieting the eye and allaying the inflammation. When the acute symptoms have decidedly abated under this treatment, the salve in the eyes once a-day may be tried, and if well borne, kept up for several weeks. It then not only allays irritation, and favors the healing of the phlyctenulæ, but promotes the absorption of the remaining opacities. After the first few weeks the quinine may be left off, or continued in smaller doses, in combination with iron; or, what is preferable, the iodide of iron may be substituted for it. When the acute symptoms and redness of the eyes are relieved, the atropin also may be suspended, and the case left to the use of the salve alone.

The eczema, and other eruptions about the face, should be smeared every night with the same ointment. It acts very promptly in relieving all scabby eruptions on the face, head, and elsewhere. Instead of fearing to heal these up, I always try to get rid of them—especially the sore nose, which keeps the eyes irritated and protracts the cure—as soon as possible. Blisters and counter-irritants of all kinds should be strictly avoided, as doing no good and increasing the eruption of the face. Should the disease of the cornea assume the form of deep ulceration and hypopium, the energetic use of atropin,

the compressive bandage, combined with paracentesis corneae once a-day, have yielded far better results than any other means that I have tried. The paracentesis often checks the progress of the ulcer immediately, and prevents perforation; or if it does not prevent perforation, it limits the lateral extension of the ulcer, and thus helps to save the cornea. I generally puncture the cornea once a-day, under chloroform if necessary, for several days, till the hypopium and extension of the ulcer are relieved. I puncture the cornea to evacuate the aqueous humor and relieve tension, without regard to the pus. After the paracentesis, the pus or lymph is rapidly absorbed. I select the outer part of the cornea for the operation, simply because it is most convenient. I cannot too highly recommend this little operation in all cases of hypopium keratitis, as recently described by Roser, Von Graefe, Weber of Darmstadt, and others. Where there is a distinct abscess of the cornea, Weber's recommendation to puncture through the collection of pus is sometimes preferable, but must be done with great caution, to prevent the too sudden evacuation of the aqueous humor. He enters the needle at the most dependent point of the pustule, and passes it obliquely through, so as to enter the anterior chamber at the upper part. The aqueous fluid thus washes out the abscess as it escapes, and the further subsidence of the pus between the lamellæ is prevented. As a rule, I much prefer puncturing away from the seat of the ulcer.

I would say, for the information of any who may wish to get a good sample of the brown salve, that it can be ordered in any quantity of Suire & Co., druggists, N.-W. corner 4th and Vine streets, Cincinnati. I will not consume space in the discussing of the merits of other forms of mercurial salves, powdered calomel, etc., in these affections. They are all useful when used with discrimination, but in my practice very much inferior to the brown salve. The use of a seton in the temple, in phlyctenular corneitis, as recommended lately in the *Ophthalmic Hospital Reports* (London), Vol. IV., part iii, by Watson, I have never tried, and probably never will. Dr. Pagenstecher, of Wiesbaden, in his *Klinische Beobachtungen*, etc., 1861, recommends a salve of the amorphous yellow oxide of mercury very highly in the same cases. I tried it some years ago, but found it was very much more irritating than the brown salve and less efficacious. In the *Ophthalmic Review* of July, 1865, is an excellent article from the pen of Dr. Pagenstecher, on the value of yellow oxide of mercury ointment, and the method of preparation and using. I have no doubt but he gives

a candid and well-formed opinion of its efficiency; but a comparative trial of the two preparations has led me to adhere to the brown salve as much preferable.—*N. Y. Medical Record.*

ON ANÆSTHETICS.

By J. M. CARNOCHAN, M.D. Surgeon in Chief to the State Emigrant's Hospital, New York, &c., &c.

I desire to present, through the pages of the *Medical and Surgical Reporter*, a general statement of the facts respecting three surgical operations which I performed, using nitrous oxide gas, administered by Dr. Colton, as the anæsthetic, and my opinion on the value of this agent as compared with chloroform and ether.

The first operation took place on the 22d of last July, and was the removal of the entire breast, and glands of the axilla, for cancer. The patient a lady of feeble health, was suffering from disease of the throat and lungs and general debility. In thirty-five seconds from the time she began inhaling the gas, she was in a profound anæsthetic sleep. She remained insensible for sixteen consecutive minutes, until the operation was completed, and in forty seconds, from the time the bag was removed, awoke to consciousness without nausea, sickness, or vomiting, as is so often the case with the inhalation of chloroform and sulphuric ether. The second and third capital operations occurred at the State Emigrant's Hospital, on the 2d of December, and consisted of two amputations of the leg. The time required to produce an anæsthetic sleep in the first patient, a male adult, extremely debilitated and worn out by disease, was forty-five seconds; whole duration of the operation and influence, two minutes and a-quarter. No nausea or unpleasant symptoms.

The third operation was on a boy of about 13 years of age. The time consumed in the inhalation, operation, and recovery from the anæsthetic sleep was two minutes, the gas working equally as in the other cases, and the patient, after complete anæsthesia, awaking entirely free from unpleasant symptoms.

For minor operations, or for capital operations, such as amputations which when properly performed should require but a few minutes, I have no hesitation in stating that the nitrous oxide gas, as an anæsthetic, is far superior to either chloroform or ether. Insensibility is suddenly produced, and the patient

recovers consciousness quickly, the operation being attended by no nausea or sickness, and without the dangerous effects often incident to chloroform and ether.

It is worthy of remark that the nitrous oxide gas approximates, in its chemical combination, to the composition of the ordinary atmosphere, and we may thus, inferentially, account for its more favorable influence. Whether it can be used in operations which from their nature require from half an hour to an hour's time, remain still to be proved by actual experiment.

The duration of the anæsthetic influence in the case of the first operation, previously alluded to, is the longest on record; and I may here state that this is the first capital operation performed under the influence of the gas, since the great discovery of Wells, of Hartford, twenty-two years ago, that a harmless sleep could be produced by a chemical agent, which could annul for the time being the greatest suffering. It is not at all improbable that had Wells lived and had the boldness to follow up his early successful experiments, chloroform and ether would never have been thought of as anæsthetics.

To G. Q. Colton is due the credit of reviving the use of this important agent, in the practice of dentistry, after a lull of twenty-two years.

The value of a safe anæsthetic agent, which can be used without anticipation of danger by the patient, is a great boon to suffering humanity, and I have related thus minutely its action in my own cases, in the belief, that if similar favorable results are met with by others, the nitrous oxide gas will supersede all other anæsthetics now in use.—*Med. & Surg. Rep.*

ON EPIDEMIC, OR ARMY ITCH.

By L. C. BUTLER, M.D., Essex, Vt.

Perhaps I cannot better respond to the request of your correspondent in the *Reporter* for Jan. 6th, than by sending a copy of the Report made to the Vermont Medical Society, with such emendations and alterations as may be necessary to adapt it to your columns. I was not aware, till since the publication of the proceedings of our State Society in the *Reporter*, that the disease in question was so wide-spread in its ravages. It seems to be limited in its circumference only by the extent of territory from which recruits were sent to and returned from the Union

army. It is not indigenous to northern soil, nor is it the legitimate offspring of any disease known among us. Nor can its history be traced among the archives of medicine. The "oldest" physician does not recognize it as a "familiar" face, and so has little advantage over the younger practitioner in its diagnosis or treatment. It is no respecter of persons. It pays no deference to age, sex, or condition. Pulpit, forum, and bar, learned and unlearned, rich and poor, are all alike the objects of its peculiar friendship. It rides in a coach as cosily as it nestles among the rags of poverty. It sits as jauntily upon the luxurious sofa in silks and satins, as upon the hard floor. It sleeps as quietly (?) upon nature's bed and under nature's broad covering, as upon the downy couch and behind damask curtains. It seems to recognize no known law of incubation, progress, or termination. That it is contagious, highly so, there is no doubt. It is somehow communicated from one to another. Sometimes from actual contact, and sometimes without; sometimes as rubeola and scarlatina, and sometimes more as an epidemic. Its progress is better defined by the intolerable itching and scratching it occasions.

So far as its appearance in these parts is concerned, it can be traced almost invariably to southern camping grounds, whence it has been transplanted by the tramp of armies, and the return of our brave boys from the "sacred soil" to their various homes. It is not a native "to our manor born." It is an importation, a peculiar child of southern generation.

In regard to its nomenclature, possibly the persevering student of Good may find in that stupendous compendium of nosology, and nosological infinitudes, some huge Latin name applied to it; but the practitioner who has seen it and treated it will be far better able to say what it is *not*, than what it *is*. It defies both nomenclature and classification. Taking Néligan as our standard, it does not belong to the *Exanthemata*. It exhibits no inflammatory tendency. Nor to the *Pustulæ*; it has no pustules. Nor to the *Squamæ*, for it produces no secretion of any laminated whitish scales on the cutaneous surface. Nor yet to the *Hypertrophæ*, or *Hemorrhagiæ*, or *Maculæ*; nor does it belong to the *Vesiculæ*. It is not *Scabies*. In this disease there is said to be a delicious satisfaction in hunting out and exposing to the full blaze of daylight, the ugly crabbed parasite, pathognomonic of it, that covers its burrowing place in the skin under a flood of water. Progress has been made in relieving the world of a pest, and momentary relief is obtained. But no such satisfaction is vouchsafed to the unfortunate victim

of "army itch." It is scratch, scratch; the more, the greater necessity; wriggle and twist "from night till hoary morn;" for the itching is quite tolerable during the daytime, but most intolerable during the night.

In many of its characteristics it corresponds most nearly with the *Papulæ*, and with the genus *Prurigo*; and yet that name gives only an inkling of some of its peculiar symptoms, while it affords no therapeutic indication.

Unlike *prurigo*, this disease is highly contagious. It has no vesicle, nor has it any pustule, yet sometimes the eruption, from the incessant irritation it occasions, forms a discharging surface, upon which scabs are formed. It seldom (in my opinion never) in its inception, is found in the groins, axilla, armpits, or between the fingers. It is always found upon the arm, forearm, chest, abdomen, or lower extremities, and, in some rare cases, upon the scalp. Sometimes it is a fine eruption, about the size of a millet seed, hardly discoloring the skin, or raised above it; then, again, it resembles rubeola, and gives a marked sensation of roughness to the cutaneous surface. The attending pruritus is sharp and stinging, causing almost incessant scratching, by which the papulæ are torn, and a minute blackish crust formed on their apices, giving the eruption a peculiar characteristic appearance. Underneath this crust is a minute red point, which fades away as a new crop makes its appearance. In long-continued cases, complicated with other skin diseases, or accompanied with severe constitutional symptoms, suppurating sores may be formed upon different portions of the body, which will test the patience of both physician and patient in their cure.

Whilst, therefore, it so nearly corresponds with the description given in the books on *prurigo*, still the remedies ordinarily prescribed for that disease will produce little, if any, curative effect in this. It is, in fact, *sui generis*, and no better name can be found for it than that which has been given to it in common parlance, from its recognized origin, "*Army Itch*." And yet, this only represents its outward manifestation, the cutaneous affection. Back of this, and perpetuating the disease, is the *materies morbi*, which the force of every pulsation sends through the whole system. To cure the one, the other must be eradicated. Constitutional as well as local remedies must be employed. The latter are useless without the former.

In accordance with these views, I begin and end the treatment with constitutional as well as local remedies, as follows:—

R. Syr. Sarsap. Comp., ----- f.℥iv.

Sodæ Arsenias, ----- gr. iv.—viij.

M. Dose, teaspoonful, morning and evening.

To this mixture, if there be considerable derangement of the stomach or biliary organs, I add, *pro re nata*, Thayer's fluid extract of iris versicolor, leptandrin, pipsissewa, or podophyllin as seems best adapted to the case. The external application is composed as follows:—

R.	Pix Burgundica, -----	℥iv.
	Hydrarg. Oxyd. Rub., -----	
	Plumbi. Oxyd. Rub., -----	
	Terebinth Veneta, -----	āā ℥j.
	Butyri Recentis, -----	℥xij.

M. (Adeps will not answer.)

The first three ingredients should be finely pulverized before being mixed with the last two, and then constantly stirred over a slow heat until all are intimately blended. Then place the dish upon ice or cold water, and stir again until the whole becomes the consistence of an ointment. A small portion of this ointment should be rubbed in thoroughly upon the eruption, morning and evening.

Great care should be observed in regard to cleanliness. The under clothing should be changed twice or thrice a-week, and an occasional ablution of the whole body with Castile soap and water, would not only tend to allay the cutaneous irritation, but expedite the cure. The diet should be carefully regulated. No pork grease in any form should be allowed. Pastry, highly seasoned food of any kind, stimulating condiments, should be avoided as directly calculated to perpetuate the disease. The patient should not be starved, but the diet restricted to those articles which are plain, simple, and nourishing, and which will not tax too heavily the digestive organs.

The course of treatment I have thus indicated, is the result of some investigation and observation. It has been adopted after a thorough trial and failure of many prescriptions. In my hands, it has been uniformly successful; I can call to mind no case which, when the directions have been carefully followed, has not been cured by it. Time, patience, and perseverance are necessary to accomplish the result, but it is sure. Recent cases are more speedily cured than those of longer duration. I write with the more confidence, because I have tested the treatment in hundreds of cases, and have yet to see the instance of failure. I prepare the remedies myself. I do not deal out the ingredients to the patients, and leave them to prepare the ointment with such grease as they may happen to have. The prescriptions are compounded carefully by weight and measure, and

just the heat necessary for their intimate mixture. And, having taken all these precautions, which I regard as important, I watch the progress of the cure, and am not disappointed in finding the intolerable itching allayed, so that the patient will enjoy a quiet night, in many instances, from the first application, and the eruption fading away and disappearing. In other localities, or in the hands of other practitioners, they may not prove as uniformly successful, but where other remedies have failed, these are spread out before the profession as being worthy, at least, of a thorough trial.—*Med. & Surg. Reporter.*

Editorial.

MEDICAL COLLEGE INSTRUCTION.—The regular clinical and reading term in the Chicago Medical College, will commence on the first Tuesday in March, and continue until the first of July. The course of instruction will consist of one clinic on Mondays, Tuesdays, Thursdays, and Fridays, in Mercy Hospital, and on Wednesdays and Saturdays in the College Dispensary, making one clinical lecture every day as a part of the regular course. In addition, the student will have free access to the clinical instruction given in the County Hospital, which is within five minutes walk from the College. Besides this ample provision for clinical instruction, at least one familiar lecture and examination will be given each day, by the members of the College Faculty. Ample material will also be furnished to those who wish to pursue dissections.

The Spring and Summer Term, as thus arranged, affords very superior advantages to all such students as can afford to remain in the city until July. It ensures a systematic course of practical and demonstrative instruction of the most valuable character, without the crowding of many topics upon the mind the same day, as in the regular winter term. It is desirable that it should be distinctly understood, however, that this summer reading and clinical term is merely supplementary to the annual lecture term, and in no case to be counted as *one college term*

by the student in making up his requirements for graduation. It has been no part of the objects of the Faculty of the Chicago Medical College to increase the *facilities* for the graduation of students, by making two lecture terms in one year, or by adhering to one short and wholly inadequate term. On the contrary, their great leading object is to induce medical students to take a higher and broader course of medical instruction, before attempting to graduate. The Summer Course is free to all the matriculants of the College.

COUNTY HOSPITAL.—At a regular meeting of the Medical Board of the County Hospital, located in this city, it was decided to open the institution, at once, for clinical instruction. For eight months of the year—from Oct. 1st to June 1st—there will be given four clinics a week, two medical and two surgical. For the remaining four months, viz.:—from June 1st to Oct. 1st, there will be two clinics a week, one medical and one surgical. The clinic days are Tuesdays and Fridays, at 1½ o'clock P.M., which will be observed throughout the entire year.

The profession of the city and country are invited to visit the hospital at any time, and especially on clinic days.

The following gentlemen have been elected and duly installed in the duties of their office:—E. T. QUALES, M.D., House Physician, W. H. HUTCHINSON, Assistant.

CHICAGO MEDICAL COLLEGE ANNUAL COMMENCEMENT.—The Annual Commencement exercises of the Chicago Medical College were held March 1st, 1866, in the Hall of the College, No. 1015 State Street. A large number of the relatives and friends of the graduating class were present, filling the Hall to its utmost capacity.

The exercises of the evening were opened by prayer by Rev. Mr. Trowbridge.

The Graduating Class.—The President, Dr. H. A. JOHNSON then conferred the degree of Doctor of Medicine upon the members of the graduating class, which was composed of the following named gentlemen:—

J. N. Bishop, H. W. Boyd, James Brewster, W. H. Buchtel, D. F. Crouse, J. W. Filkins, C. Hamilton, H. Harris, W. Horne, D. S. Jenks, C. T. Johnson, J. F. Kelsey, E. A. Lee, J. McCarthy, H. C. McCoy, S. A. McWilliams, W. E. Morris, W. A. Nason, Henry Shimer, Lyman Ware, N. W. Webber, Herbert York.

Ad Eundem—Drs. W. H. Baxter, W. S. Caldwell, George H. Calkins, W. D. Carter.

Honorary—Drs. J. Charlton, S. France, W. C. Matchette, J. P. Randall, L. D. Robinson.

The prizes for the best theses were conferred on S. A. McWilliams and Henry Shimer.

Address of the President.—After the class had received their diplomas, the President addressed them as follows:—

In the early history of the medical profession it was customary to require candidates for medical honors to take an obligation to faithfully perform the duties of their profession. We have not required of you, gentlemen, formally, this obligation; but in conferring upon you the degree of doctor of medicine the College is in the most emphatic manner indorsing your professional character, and recommending you to the public confidence. In accepting this degree, you are under the implied obligation no less binding than the Hypocratic oath, to faithfully and truly perform the duties of the high calling to which you have this evening, consecrated your lives. You are virtually pledged to a life-long service in the fields of science and art. You have promised to conscientiously use the power and influence of your profession for relieving suffering, and for the promotion of the best interests of humanity. In the name of the College, then, I charge you to cultivate science with an earnest desire to know the truth and to practice the art of medicine and surgery, ever remembering its legitimate use—the relief of suffering and the lengthening, if possible, of human life. And, finally, to cherish in your own hearts every social virtue, loving purity, goodness, and truth; so shall your lives be honored and your memories cherished.

Award of Prizes.—Dr. N. S. DAVIS then presented to Messrs

S. A. McWilliams and Henry Shimer the prizes for having written the best theses in the class. Mr. S. A. McWilliams received the first prize, which consisted of a photographic likeness of the donor, Dr. DAVIS. Mr. Shimer received the second prize, a copy of the transactions of the Chicago Medical Society from the year 1856 to 1864.

The Valedictory.—Prof. WM. H. BYFORD then delivered the valedictory address to the graduating class. The subject of the lecture was “The Philosophy of Trades and Professions.” The lecturer said that the great end of learning trades and adopting professions was to get money. The great aims were selfish; but the professions of medicine and divinity were exceptions, for the practitioners in both these professions aimed at doing good. The physician could not do like the tradesmen, —“get all he can and keep all he gets,” but his services were paid for according to the generosity of the people.

The speaker then proceeded to show the relation that the physician bore to the other two learned professions. The three learned professions had their foundation in the weaknesses of mankind. The legal profession was brought into existence because there were in the world weak men and rascals. The doctor had to deal with the bodily ills of mankind, and the clergy had the moral evils of the world to repair. The lecturer proceeded to show the vast field of knowledge open to the medical practitioner, and advised each one of the class to turn his attention particularly to some branch of the profession, since it was impossible that one person should be profound in them all.

He closed by thanking the class for their uniform diligence and good conduct while members of the Institution, and hoped they would all honor the profession they had adopted, and the College from which they received their diplomas.

At the close of the exercises, the President announced that the graduating class, together with their friends, would repair to the residence of Dr. Hollister, No. 30 Washington Street, where a bountiful supper would be served.

The meeting then adjourned.

At the residence of Prof. Hollister, the company enjoyed

not only an elegant entertainment, but a most delightful social conference, which was not terminated until a late hour of the night.

CHICAGO MEDICAL SOCIETY.—*Pathological Specimens and Cases.*—At the regular meeting of this Society, held February 9th, 1866, Dr. N. S. DAVIS presented the heart of a patient, whose history was briefly as follows:—About eight months previous to his death, he was thoroughly exposed to cold and wet, resulting in an attack of rheumatic fever that continued several weeks. After the fever subsided, he so far regained his health as to be able to do some work, but never fully recovered. His breathing was embarrassed whenever he took exercise, and about six weeks before his admission into Mercy Hospital his feet and ankles began to be oedematous, and his respiration more oppressed. The oedema increased rapidly, and at the time of his admission, which was the first of his coming under the observation of Dr. DAVIS, the superficial areolar tissue, not only of the upper and lower extremities, but through the whole extent of the body, was thoroughly oedematous, giving to the patient a very bloated aspect. His respiration was extremely difficult, accompanied by a mixture of dry, wheezing, and sharp submucous rhonchi through the whole extent of the chest, with decided dulness over the lower and posterior parts of the lungs. His countenance was pale, bloated, and expressive of anxiety; pulse feeble, frequent, and intermitting; the impulse of the heart feeble, and the systole accompanied by a loud, harsh, and prolonged bellows murmur, most intense one inch directly below the nipple, and a slighter rough sound with the diastole; urine very scanty and highly albuminous; little or no appetite, and bowels inclined to constipation. The case was made the subject of a clinic, and each member of the class in attendance had an opportunity to listen to the sounds of the heart and lungs.

The diagnosis was, extensive thickening of the valves in the left cavities of the heart, from previous endocardial inflammation; renal congestion with universal anasarca; and some oedema of the lungs, the latter threatening to terminate the life

of the patient by suffocation in a very short time. As was anticipated, the pulmonary œdema rapidly increased, and the patient died on the third day after admission. The heart, which was the only part presented to the Society, was moderately increased in size as a whole, and covered with more fatty tissue than natural. There were no external traces of inflammation. On opening the cavities of the right side, the appearances were strictly natural. Both the auriculo-ventricular and the pulmonary artery valves were perfectly free from any abnormal changes. On opening the left ventricle its whole interior surface was red and roughened, from previous inflammation. The columnæ carnæ were unusually thick and their surfaces rough, and the shape of the cavity somewhat altered. It seemed to be contracted at the base, and enlarged, so as to appear slightly sacculated, at the apex. At the base the walls were thick, but thinner than natural towards the apex. The mitral valve was extremely thickened and so changed in color and texture as to resemble the columnæ carnæ in appearance, and almost as hard as cartilage. The thickening of this valve had so narrowed the opening from the left auricle to the left ventricle that it would not admit the end of the little finger. The semi-lunar valves of the aorta were also so much thickened and indurated as to present quite a serious obstruction to the egress of blood from the ventricle. These changes fully explained the constant fulness of the pulmonary veins and the consequent capillary congestion, dyspnoea, with final pulmonary œdema and death.

Dr. T. D. FITCH presented the morbid specimens obtained from the base of the cranium and membranes of the brain, belonging to the case related to the Society at a previous meeting, and reported in the EXAMINER for February.

Dr. J. P. ROSS related a very interesting case of extreme abdominal tympanites, ending in pneumothorax, with emphysema at the top of the chest, and death. The case was a laboring man, who had complained of some gastric symptoms, or indigestion, for one or two years, but not so severe as to prevent his regular labor, and the day previous to the attack had been at his work and as cheerful as ever. On his way home at

evening, he was attacked with severe pain in the stomach, and stopped at a drug-store, obtained a dose of cathartic pills, and took them. They did not operate, however, and, before morning, the pain in the epigastric and left hypochondriac regions became so intense as to be scarcely endurable. Dr. CLARK was called very early in the morning, and prescribed full doses of anodynes internally and fomentations externally. At that time, there was no tympanites; no febrile reaction; and the pain was still restricted to the region of the stomach. About the middle of the afternoon, however, Dr. Ross was called in, and found the patient still in very great distress, and with an extraordinary degree of tympanitic distension of the abdomen. The pressure against the diaphragm was sufficient to render respiration very short, and the abdominal walls were, literally, as tense as a well-corded drum. On attempting to give an enema, it was found impossible to force anything into the rectum. In a few minutes after, while being turned partly upon one side, the patient felt something give way, with a sound audible to the by-standers, and in a moment the respiration became so greatly oppressed as to threaten immediate suffocation. The whole left side of the chest became almost as tympanitic as the abdomen, and an emphysematous swelling appeared in the space above the clavicle. In a few moments, the patient died, apparently from suffocation.

A strong effort was made to procure the privilege of making a *post mortem* examination, but without success. It would seem probable, from all the symptoms, that perforation of the stomach took place at the time the intense pain commenced; that the enormous accumulation of gas which was in the peritoneal sac, by its pressure, not only greatly distended the abdominal parietes and collapsed the intestines, but finally forced a passage through the diaphragm, filling the left side of the chest and following the areolar tissue of the mediastinum to the top of the chest, presenting there an emphysematous tumor above the clavicle. It was certainly an extraordinary case, and the refusal of friends to allow a proper *post mortem* examination deserves severe censure.

DEATH OF DR. I. P. LYNN.—At a meeting of the profession, held at the Council Chamber, Chicago, March 2d, 1866, on the occasion of the death of Dr. I. P. LYNN, Dr. R. C. HAMILL was elected Chairman, and Dr. THOS. BEVAN, Secretary.

On motion, Drs. ALLEN, BLAKE, and MILLER were appointed a committee to draft suitable resolutions in relation to the melancholy event.

Dr. E. INGALLS made a brief address, eulogistic of the estimable qualities of our departed confrère.

Dr. J. A. ALLEN, from the Committee on Resolutions, reported as follows:—

Resolved, That the intelligence of the sudden and untimely death of our late friend and co-worker in the medical profession, ISAIAH P. LYNN, M.D., is received by this meeting with emotions of profound pain and sincere sorrow.

Resolved, That the memory of our deceased brother will be cherished by us as of one who, personally, and by his amiable disposition and fine friendly feeling, endeared himself to all who knew him intimately; whilst, by his conscientious earnestness in acquainting himself with the principles of medical science, and thorough devotedness to the welfare of those who entrusted themselves to his care as patients, he commanded the confidence, the respect, and esteem of both the profession and the public.

Resolved, That we tender to his bereaved family and friends, the assurances of our warmest sympathy in this their great affliction.

Resolved, That copies of these resolutions be presented to the relatives, the public press, and medical journals of this city for publication.

On motion, the report was accepted and adopted unanimously.

On motion of Dr. HAY, it was resolved that the profession attend the funeral in a body.

Dr. J. A. ALLEN then occupied the meeting with appropriate remarks, highly creditable to the amiable character, kindness, and faithfulness of the lamented dead. He also referred to the peculiarly sad circumstances of the immediate cause of death, giving an entirely satisfactory explanation of the accident which had resulted so unfavorably.

Dr. V. L. HURLBUT followed Dr. ALLEN in a similar vein.

Drs. BROOKS and McVICKAR referred feelingly to the courtesy and worth of the deceased, Dr. M. giving some incidents of his personal relations to the Doctor, of a very pleasant character.

Drs. N. S. DAVIS, S. WICKERSHAM, and D. L. MILLER also addressed the meeting, expressing their cordial endorsement of the resolutions, and of the sentiments of sympathy and respect which had been expressed by other speakers.

On motion, the meeting adjourned.

THOS. BEVAN, M.D., *Sec'y.*

CHICAGO MEDICAL JOURNAL.—This medical periodical has changed hands, editorially, and at the same time improved its typographical appearance. We wish its new editors much enjoyment in their editorial labors and abundant success.

AMERICAN MEDICAL ASSOCIATION.

The Seventeenth Annual Session will be held in the City of Baltimore, on Tuesday, May 1, 1866.

The following Committees are expected to report:—

On Prize Essays, Dr. Austin Flint, Sr., N.Y., Chairman.

On Quarantine, Dr. Wilson Jewell, Pa., Chairman.

On So-called Spotted Fever, Dr. Jas. J. Levick, Pa., Ch'n.

On Ligature of the Subclavian Artery, Dr. Willard Parker, N.Y., Chairman.

On Tracheotomy in Membranous Croup, Dr. Alex. N. Dougherty, N.J., Chairman.

On Rank of Medical Corps in the Army, Dr. C. S. Tripler, U.S.A., Chairman.

On Rank of Medical Corps in the Navy, Dr. T. L. Smith, N.Y., Chairman.

On Medical Literature, Dr. C. A. Lee, N.Y., Chairman.

On Medical Education, Dr. Samuel D. Gross, Pa., Chairman.

On American Necrology, Dr. C. C. Cox, Md., Chairman.

On Patent Rights and Medical Men, Dr. David Prince, Ill., Chairman.

On Alcohol and its Relations to Man, Dr. Gerard E. Morgan, Md., Chairman.

On Insanity, Dr. Alfred Hitchcock, Mass., Chairman.

On Milk Sickiness, Dr. Robert Thompson, Ohio, Chairman.

On the Relation which the Doctrine of the Correlation and

Conservation of Forces bears to the Physiological and Pathological Condition of the Human System, Dr. S. L. Loomis, D.C., Chairman.

On the Progress of Medical Science, Dr. Jerome Candee Smith, N.Y., Chairman.

On Diphtheria, Dr. H. D. Holton, Vt., Chairman.

On the Comparative Value of Life in City and Country, Dr. Edw. Jarvis, Mass., Chairman.

On Drainage and Sewerage of Cities in their Influence on Health, Dr. Wilson Jewell, Pa., Chairman.

What Effect has Civilization on the Duration of Human Life, Dr. Augustus A. Gould, Mass., Chairman.

On Disinfectants, Dr. E. M. Hunt, N.J., Chairman

On Compulsory Vaccination, Dr. A. Nelson Bell, N.Y., Ch'n.

On Strangulated Hernia, Dr. W. F. Peck, Iowa, Chairman.

On the Causes and Pathology of Pyæmia, Dr. J. J. Woodward, U.S.A., Chairman.

On the Use of Plaster of Paris in Surgery, Dr. Jas. L. Little, N.Y., Chairman.

On the Etiological and Pathological Relations of Epidemic Erysipelas, Spotted Fever, Diphtheria, and Scarlatina, Dr. N. S. Davis, Ill., Chairman.

On Meteorology, Medical Topography, and Epidemics, Drs. J. C. Weston, Me.; P. A. Stackpole, N.H.; C. L. Allen, Vt.; A. C. Garratt, Mass.; C. W. Parsons, R.I.; B. H. Catlin, Ct.; E. M. Chapman, N.Y.; E. M. Hunt, N.J.; D. Francis Condie, Pa.; T. Antisell, D.C.; O. S. Mahon, Md.; T. M. Logan, Cal.; R. C. Hamill, Ill.; J. W. H. Baker, Iowa; Abm. Sager, Mich.; J. W. Russell, Ohio.

WM. B. ATKINSON.

Permanent Secretary, Philadelphia.

INCREASED USE OF STIMULANTS IN THE LONDON HOSPITALS.
—Some remarkable statistics, regarding the employment of stimulants and the mortality in the London Hospital during some past years, appear in the last volume of the *Reports* of that hospital. In 1862, the number of in-patients was 4519, and the general mortality 7.6 per cent. The quantity of stimulants consumed was 1281 gallons of wine, 162 gallons of brandy, 38 gallons of gin, and 1100 ounces of cinchonine.

In 1864, the number of patients was 4619, and the general mortality 10.5 per cent; the stimulants consumed by these being 1558 gallons of wine, 359 gallons of brandy, and 77 gallons of gin. But as a set-off, if it may so be called, 760 more leeches were employed during this year than the average for

the five preceding years, viz.: 3840. However, here we have a great increase in the amount of stimulants consumed, and also a great increase in the mortality of 1864, as compared with that of 1862. We state the facts, let it be understood, without in any way pretending to connect them as cause and effect.

Other statistics, Dr. Fraser gives us under this head:—"From 1854 to 1858, the annual average quantity of wine employed by each physician was 12,803 ounces;" each physician having an annual average of 391 patients under treatment. The annual average mortality was 11.87 per cent. But from 1860 to 1864, the annual average quantity of wine employed by each physician was nearly quadrupled, being 48,136 ounces; his annual average number of patients was 413; and the annual average mortality was 12.65 per cent.

From 1854 to 1858, each surgeon employed annually 38,016 ounces of wine; his annual number of patients was 1036; and the annual average mortality 4.48 per cent.

From 1860 to 1864 (five years,) each surgeon employed an annual average of 142,951 ounces of wine (nearly four times more than in the previous years;) the annual number of patients under him was 1065; and the annual average mortality 6.65 per cent.

Hence, we have, in the practice of both physicians and surgeons, a distinct increase of mortality coincident with great increase in consumption of stimulants.

Dr. Fraser also tells us (referring to a former paper of his) that, in 1851, there were 4051 in-patients in the London Hospital; that in 1857, there were 3935 in-patients; and that the mortality was greater in 1857 as 8 to 6.5 per cent, although £962 more were spent in 1857 than in 1851 for articles of luxury.

It is curious to note, that the only comment which Dr. Fraser makes on the above remarkable statistics is this:—

"It is evident, that a steady rise in the employment of stimulants-----is still going on; and whatever be the cause, we may rest assured that the practice is imperative and needful; for it would be a monstrous assumption that a whole staff could be blindly following an objectless routine."

Not a single word of comment does Dr. Fraser bestow on the constant fact of the coincident increase of the mortality!

The summary of these statistics stands thus:—

From 1854 to 1858, each physician employed 12,800 ounces of wine annually; the deaths being 11.88 per cent. From 1860 to 1865, he employed 48,136 ounces; the deaths being 12.65 per cent.

During 1854 to 1858, each surgeon employed annually 38,016 ounces of wine; the deaths being 4.48 per cent. During 1860 to 1864, he employed annually 142,951 ounces; the deaths being 6.65 per cent.

In 1862, the general mortality of the hospital was 7.4 per cent; the consumption of stimulants being 1281 gallons of wine, 162 of brandy, and 38 of gin.

In 1864, the mortality was 10.5 per cent; the quantity of stimulants consumed being 6558 gallons of wine, 359 of brandy, and 12 of gin.

We again repeat, well knowing the sad fallacies which are so often edited through an erroneous interpretation of statistics, that we do not pretend to connect the increase of deaths with the increase of stimulants consumed. But, when we reflect upon our modern advancement in medicine and surgery (especially as miscalled conservative,) when we think of our great modern hygienic efforts, we may fairly ask for some explanation of the fact of a general advance in the mortality of a London Hospital.—*Brit. Med. Jour.*, Dec. 9, 1865, and *Medical News*.

VACCINE MATTER FROM THE COW.—M. Lanoix has read a paper on this subject before the Academy of Medicine at Paris. This physician, after studying the subject at Naples, is founding in the capital of France an establishment for such vaccination. In the paper it is stated that out of 820 revaccinations practised in different schools upon children from 7 to 13 years old 21 per cent. succeeded. The figures respecting a more advanced age are as follows:—From 14 to 20 years, 71 revaccinations, 31 effectual; from 30 to 40 years, 200 revaccinations, 97 effectual; from 40 to 55 years, 30 revaccinations, 7 effectual; from 50 to 60 years, 5 revaccinations, 2 effectual. The author considers that the transmission of vaccine matter from heifer to heifer is always possible, the quantity obtained being quite adequate to very numerous operations; that the matter does not lose in activity in passing through animals as it does in passing through human organisms; that vaccinations are always or almost always successful; the revaccination with animal matter succeed more frequently than with matter obtained from human beings; that vaccination with heifer matter is extremely easy; and that such vaccinations are highly useful in epidemics of small-pox, as larger supplies of vaccine matter may rapidly be sent to extensive tracts of country.—*London Lancet*.

BERKSHIRE MEDICAL COLLEGE.

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